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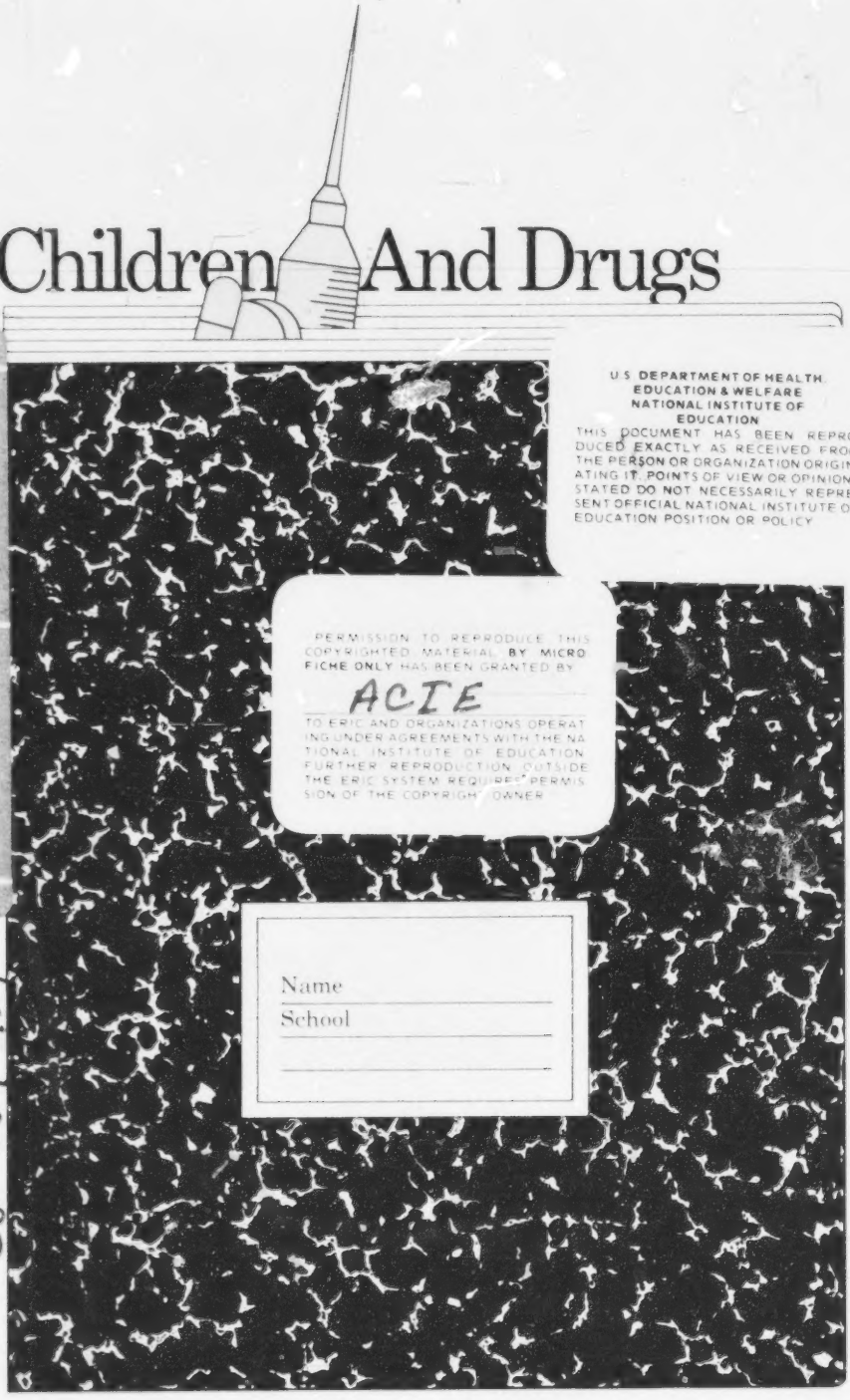
ABSTRACT

This bulletin attempts to set the problem of drug abuse among children in its social perspective. It includes a reprint of the report of the Conference on the Use of Stimulant Drugs in the Treatment of Behaviorally Disturbed Young Children, and offers guidelines to the teacher who may suspect a child is using drugs. Also included are suggestions for effective ways of working with children and their parents that may help to bring about changes in education and society that could eradicate the need for drug abuse. Several programs for drug education and a bibliography are also included. (Author/LKP)

Children And Drugs



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Children And Drugs

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Foreword

Why *this* bulletin? Why this bulletin from *ACEI*?

The drug abuse problem—always present somewhere in the world—formerly was confined primarily to adults and youth. Within the last ten years, drug abuse has sifted downward to earlier and earlier ages. Young people in secondary schools began "experimenting" and in the last three or four years, more and more reports have been released on similar drug abuse among elementary age children. The problem is worldwide and spreading fast; it now concerns young children, even babies born to drug-addicted mothers.

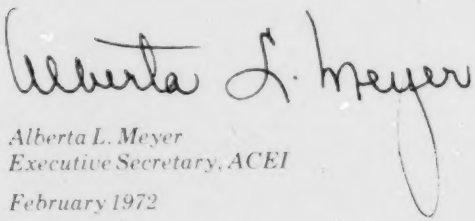
This drug abuse is a legitimate concern of the Association for Childhood Education International. With deep interest in the education and well-being of children from infancy through pre-adolescence, the members of the Association, most of whom work with elementary school children, need to be aware of the "drug culture" and the factors that have caused drug abuse to surface in younger and younger children. Because of our deep concern for all children, we also need to know how best to help them, their parents and their communities. This bulletin is offered to its readers with these goals in mind.

Children and Drugs attempts to set the problem in its social perspective. It includes a reprint of the report of the Conference on the Use of Stimulant Drugs in the Treatment of Behaviorally Disturbed Young Children, and offers guidelines to the teacher who may suspect a child is using drugs. Since the causes of drug use are almost always complex, there are suggestions for effective ways of working with children and their parents that may help to bring about changes in education and society that could eradicate the need for drug taking.

Obviously, one of the ways to combat drug taking in younger children is to make education more vital and exciting, so that drugs will not be needed. And that is

what ACEI's total program is about—the work of its Branches and State/Province Associations, its Study Conferences and Summer Study Programs, and its publications—all are intended to help adults make learning more fun for children.

Readers may wish to refer to the sample list of ACEI publications on page 64.



Alberta L. Meyer
Executive Secretary, ACEI

February 1972

Contents

3 **Foreword**
Alberta L. Meyer

6 **Introduction**
Congressman James H. Scheuer

10 **Encountering the Drug-Using Child**
Marvin R. Levy

18 **Parents, Teachers and Community**
Donald B. Louria, M.D.

24 **Report**
Conference on stimulant drugs in the Treatment of Behaviorally Disturbed Children

Afterwords:
Comments by Arnold Arnold and Reginald S. Lourie, M.D.

38 **Drugs, Education and Children**
Donald A. McCune

44 **Programs for Drug Education**
Patricia Hill

54 **Bibliography**
Anthony James DelPopolo, Sr.

Drug abuse is not a new problem in America. We have been attempting to cope with some form of narcotic drug abuse at least since soldiers wounded in the Civil War became addicted to the pain-killer morphine.

However, the problem has recently increased in scope and magnitude, until today, in the words of President Nixon, it "has assumed the dimensions of a national emergency":

More young people in New York City between the ages of fifteen and thirty-five die as a result of narcotics *than from any other single cause.*

Each year in New York City about 1,000 babies are born addicted to heroin as a result of the addiction of their mothers.

Each year narcotic addicts commit one-half of our violent street crime in attempts to obtain means to support their habits.

Each year one-quarter of a million arrests are made for drug-related offenses in New York City.

In short, narcotics addiction and the "pill-culture" together threaten to destroy both our youth and our cities. This epidemic is turning thousands of our children into physical and psychological cripples. It is overwhelming our police, clogging our judicial machinery, and turning our cities into battlefields by day and deserts by night.

The response of the federal government to this problem has for the most part centered about efforts to strengthen our law enforcement activities. Here at home, the major legislative effort to date has been the enactment of the Comprehensive Drug Abuse Prevention and Control Act of 1970. This law, designed to provide strict legal controls over narcotic and synthetic drugs subject to abuse, has made a valuable contribution to solving the problem.

Our international activities have involved efforts to eliminate the supply of opium and its derivatives—morphine, codeine, and heroin—which, as the President noted, are "foreign imports" produced abroad. We have undertaken negotiations with the major suppliers of these narcotic drugs to induce them to end production, and we have supported similar efforts of the United Nations through such new institutions as the United Nations Special Fund for Drug Abuse Control. We have proposed amendments to strengthen the 1961 Single Convention on Narcotic Drugs, the major treaty controlling the international traffic in opium and its derivatives. Finally, the President has submitted to the Senate for its advice and consent a new treaty which attempts to control the international traffic in the synthetic drugs, which are ravaging our college campuses and our cities.

All of these law enforcement efforts are directed towards reducing the supply of dangerous drugs. But experience proves that efforts to solve the problem of abuse by dealing *only* with supply are doomed to failure.

Enough opium to supply the entire annual United States demand for heroin can be produced in a total area of five to ten square miles. Since the poppies which produce this opium are raised in a geographic area stretching from Southeast Asia to the Middle East as well as in such places as Mexico, the chances of totally eliminating illegal poppy culture in the near future are slim indeed.

Moreover, once the opium is refined into morphine base and then into heroin, the chances of preventing its entry into this country and its distribution throughout our cities and our rural areas are virtually non-existent. Large amounts of heroin can be smuggled into this country in containers as small as lipstick tubes. There are literally thousands of places on ships, on planes and in cars to hide heroin containers of this size or larger and, given the 65 million cars and trucks, 300,000 planes, and 156,000 ships which enter this country each year, it is virtually impossible to prevent heroin from entering the country or, once here, from stopping its distribution.

As long as there is a demand for heroin, the extraordinary high profits involved will guarantee that some people will take risks, even very grave ones, to produce and distribute it.

The same is true of the synthetic mind-altering substances—the "pills." These drugs, the amphetamines, barbiturates, tranquilizers, and other new and as yet unknown substances which haven't even been invented, can be produced in a relatively simple manner by people with comparatively little chemical knowledge. Again, as long as there are high profits involved, some people will always be found to take risks to produce and distribute these substances.

Thus, if we are to stem the tide of drug abuse, we must begin immediately to deal effectively with the *demand* for drugs.

This will not be an easy task.

We live in a country which in a myriad of ways encourages people to achieve "better living through chemistry." We encourage people to take pills for every imaginable complaint, from headaches to insomnia. Worried? Take a pill. Can't sleep? Take a pill. Overweight? Take a pill. Sleepy? Take a pill. Upset stomach? Take a pill. Annoyed or irritated—on the job or in the kitchen? Take a pill.

This belief in the magic power of pills extends even to those in our society who should know better—our doctors. In 1970, pharmacists filled more than 225 million prescriptions for these drugs compared with 166 million in 1965. This 37 percent increase compares with a 32 percent increase for all prescription drugs during the same period.

In this type of atmosphere, including paralyzing saturation television exposure, is it any wonder that our children look upon mind-altering substances as acceptable, appropriate, even *desirable* everyday phenomena to which no moral stigma is or should be attached? Is it any wonder that people in our slums, faced with a world of harsh reality that approaches the intolerable, reach for drugs as an escape?

We must begin to change our attitudes towards the use of drugs to alter our moods and to correct our minor complaints.

To do so will require an educative process which we have yet to conceptualize—much less to develop.

No reliable study has indicated that current drug education programs effectively prevent potential drug abusers from experimenting with narcotics or pills. In fact, we are just now beginning to realize that dramatic overstatements in the form of poster slogans such as "Marijuana—the Killer Drug" are not only ineffective and treated as jokes by the people they are designed to educate, but also reduce our credibility when we seek to warn the kids about the really dangerous drugs—the narcotics—heroin, cocaine, morphine—and the pills—amphetamines,

barbiturates, and tranquilizers. We have not even begun to design programs that will reach and persuade sophisticated college students as well as knowledgeable ghetto youths who have lived in an atmosphere permeated with the drug culture for their entire lives.

We must begin by developing the best factual evidence possible on the effects of drugs of abuse and then we must disseminate this knowledge in an informed, intelligent manner to our children. We must inform them that the use of certain drugs is illegal and explain to them why this is so. We must educate them as to the psychological effects of these drugs and develop in them a sense of caution whenever they even consider the introduction of a mind-altering substance, licit or illicit, into their bodies. We must instill in them a realization that the use of drugs to affect one's psychological state, no matter how apparently harmless, may be the first step into the "drug culture" which may lead to a life of crime or even death. Finally, we must do all of this in a way that is not transparently inaccurate, moralistic, and hypocritical; in a way that explains the difference between the cultural acceptance of some substances but not others; in a way that does not condemn or unreasonably make illegal substances which we are ourselves unwilling to forego.

The Congress and the President have made steps in this direction. We have enacted a Drug Abuse Education Act, to develop and fund effective drug abuse education programs. We have established a commission on marijuana to study the drug and to make recommendations on its legal status. Finally, the Congress has enacted legislation recommended by the President, and long advocated by me and others; to establish in the White House an office to deal comprehensively with drug abuse on a high priority basis.

These are some of the measures the government has taken. But, much remains for the ordinary citizen. He must inform himself and his children factually, honestly, and without sanctimonious cant or hypocritical sermonizing about drugs and their dangers. He must examine his own behavior with respect to mind-altering substances to determine whether consciously or unconsciously he is encouraging his children in the unnecessary use of drugs. Finally, he must support government and community efforts that attempt to deal with the problem in an honest, intelligent and effective manner.

Drug abuse poses a real threat to the health and well-being of our nation. We must rise to the challenge. The fabric of our cities, the integrity of our campuses, the well-being of a whole generation of future leaders are at stake.

Drug abuse represents a general pathological response to inner and outer stresses with which people cannot cope. The origins are complex and much remains unknown. The obscure etiology makes early recognition a difficult task indeed, although hopefully not an insurmountable one. Intervention is a challenge to the rational judgment and creative skills of a teacher.

Before an individual becomes drug-dependent, the early recognition of his drug use may serve to interrupt a progressive pattern of promiscuous use and break an otherwise inevitable chain of events. Detection of the student beginning to experiment with drugs, however, is virtually beyond the diagnostic skills of most physicians.

It is difficult to recognize even the most bizarre symptoms accompanying long-term use of drugs which produce the classic withdrawal syndrome. More often, the drugs abused by the elementary school youngster are usually ones that do not produce marked symptoms. Therefore procedures such as blood and urine analysis tests are of dubious value. Teachers are hardly prepared to recognize even chronic and compulsive drug abuse and certainly cannot be expected to identify the beginning stages of drug experimentation.

While the possession of devices such as hypodermic needles and syringes, modified eyedroppers, blackened or charred spoons, which are the hallmarks of the hardened addict, should be a basis for investigation, they are seldom commonplace in the drug-using patterns of younger children. Admittedly, there are always exceptions. Tissue damage or chronic irritation and inflammation around the nose and mouth should be cause for concern though they may, of course, have innocent origins. It would be irresponsible to consider these suspicions as *prima facie* evidence of drug taking. Spurious accusations can cause serious harm to the child, his family, and the school. Few elementary school children involved with drugs use substances that produce overt symptoms or that require the related paraphernalia which provoke suspicion.

Drug abuse among the young stems from an amalgamation of factors: social, cultural, anthropological, historical, psychological and possibly physiological. These have been the subject of disciplined investigation. Also identified have been correlated traits of character, personality, somatotype, and physiology which predispose some individuals to drug dependency while other individuals with similar characteristics are seemingly resistant. Attempts to delineate the "drug-prone personality" have been numerous. Expert opinions about these predispositions vary so much that they preclude any consistent conclusions.

Despite the difficulties of recognizing a specific drug-abusing "type," the teacher is nevertheless in a strategic position to observe and evaluate pupil behavior.

Assessment of learning disability and investigation of cogent reasons for underachievement are the inherent responsibilities of the elementary school teacher. Certain changes frequently accompany drug abuse and it is vital that teachers be alert for any marked change in previous behavior or sudden deviation from former standards.

Often the drug-abusing youngster will attempt to conceal his involvement. It is extremely unlikely that he will come to school intoxicated, high, nodding, or in any way behaving in a drugged state. These conditions will generally be confined to after-school hours, to weekends, or during vacation periods. He may avoid coming to school on days when he feels his behavior will reveal his drug-taking activities and his school attendance may become irregular. Hence truancy may be one of the earliest signs that something is wrong. As his involvement increases, he often tends to isolate himself from classmates, becomes evasive about his activities, limits his communication with others, and generally experiences a decline in school work and academic interests. It is common for small episodes of stealing to occur. He may pilfer household items or money; he may resort to shoplifting to ease the strain on pocket-money allowances, even the most liberal ones.

Physical behavioral aberrations associated with drug use can be identical with the signs of non-drug-related health anomalies. Nevertheless, when such conditions are observed, the student should be referred to school health services for investigation, referral and follow-up.

All drugs that are psychoactive (alter mood, behavior or perceptions) can intoxicate, dull or confuse the brain. When periods of stupor, or odd and disturbed behavior occur in the youngster who ordinarily exhibits appropriate responses, they may be cause for suspicion of drug use. Continual use of these substances often results in marked changes in interests and personality.

Some types of drugs dilate the pupils of the eyes. These include the amphetamines, cocaine and psychedelics. They can produce substantial weight loss, behavior may become irrational and often there is marked depersonalization. Activity increases. Talkativeness, excitability, irritability and nervous tendencies are common. Far less common are hallucinations, paranoid tendencies, and suicidal or homicidal tendencies. Paradoxically, exhilaration and abnormal cheerfulness can occur. Nausea and vomiting, chilliness and tremulousness are sometimes seen.

The opiates, which include drugs like morphine, heroin, and codeine, constrict the pupils of the eyes and the eyes become reddened and watery. The user is generally sedated, inattentive and lethargic. Thickened or slurred speech and strong body odors may be noted.

Barbiturates are sedatives that generally produce relaxation. Higher doses produce quarrelsome behavior and intoxication with variable loss of muscular coordination such as staggering gait. Alcohol produces similar symptoms but, unlike barbiturates, alcohol can usually be detected on the breath.

Airplane glue, gasoline, lighter fluid, nail polish, paint removers, etc. are products which contain toluene, naphtha, benzene, acetone or other volatile solvents. Aerosol sprays are sometimes used, since the propellant, Freon, can produce lightheadedness, stupor, and partial suffocation. Although Freon is not a solvent which intoxicates, the difference in effect is hardly discernible by the young sniffer. All volatile solvents produce irritation and inflamation of the eyes, nose, and respi-

ratory tissues. Accompanying effects include slurring of speech and loss of motor coordination, drowsiness, disordering of perceptions, double vision, and ringing in the ears.

The effects of marijuana smoking are relatively unpredictable. The symptoms experienced by the user are probably due more to his predilection or expectations than to the pharmocologic effect of cannabis. In addition, the quality of marijuana varies considerably depending upon the amount of tetrahydrocannabinol (believed to be the principle active ingredient) in the product being smoked. Physical effects are patently indiscernible in small doses. The heavy or chronic smoker may develop a reddening of the whites of the eyes and inflammation of the throat and bronchial tubes. Behavioral manifestations include a feeling of relaxation or euphoria, a loosening of inhibitions, distortion of time and space, and periods of fantasy. Occasionally, confusion and anxiety occur. Most of these effects however, depend upon the experience and sophistication of the smoker. Neophytes are more likely to experience either no effect, or a feeling of loss of control, or protracted giggling. The more experienced user will more commonly be relaxed, quiet and introspective. The chronic and compulsive user may experience an exaggerated sense of his own capabilities.

It serves little purpose to rank-order the drugs likely to be used by the elementary school age youngster since the frequency of such use is usually determined by local exigencies, availability and peer practices. In addition, there is no valid stepping-stone theory to drug use. However, several studies conducted in the United States during the past few years suggest that the following drugs are the ones the elementary school teacher might expect to encounter in her work with her pupils:

1. Volatile chemicals and aerosols, particularly airplane glue
2. Cough syrups, particularly codeine-laced preparations
3. Beverage alcohol, particularly wine
4. Marijuana
5. Amphetamines, particularly diet pills (Dexadrine)
6. Barbiturates, particularly sleeping pills (Seconal)
7. Tranquilizers, particularly Miltown, Equanil, and Valium
8. Heroin

Ostensibly then, the most reliable indicator of drug abuse in a child is any significant change in, or deviation from, normal behavior patterns or attitudes.

When there is good reason to suspect that a child is using drugs, certain approaches may prove to be more effective than others. Direct accusations based on flimsy or unsubstantiated evidence are motivated more by fear or ignorance than by objective reasoning.

Chart Listing Drugs Elementary Teacher is Likely to Deal With

Name		Slang Names	Chemical Names
Volatile chemicals and aerosols		Glue, gas, flasher, Kidstuff, spray.	Toluene, naptha, benzene, acetone, Freon, xylene, amyl nitrite.
Cough syrups		Schoolboy.	Methylmorphine
Beverage alcohol		Smoke, booze, juice, downer.	Ethyl alcohol
Marijuana		Weed, stick, roach, reefer, pot, joint, hay, hash, grass, gage.	Cannabis sativa
Amphetamines		Uppers, speed, purple hearts, meth, jolly beans, dexies, crystal, bennies.	Benzedrine, Dexedrine, Desoxyn, Methedrine.
Cocaine		Snow, coke, stardust.	Methylester of benzoylecgonine
Barbiturates		Downers, rainbow, yellow jacket, red devil, goofballs, blue angels, barbs.	Phenobarbitol, Nembutal, Seconal Amytal
Tranquilizers		Downer	Meprobamate, chlordiazepoxide.
Heroin		Smack, skag, lemonade, horse, hardstuff, H dynamite & dolly.	Diacetylmorphine

Effects Sought	Physical Symptoms	Behavioral Symptoms	Hazards
Intoxication, euphoria, kicks.	Red eyes, irritated & inflamed nostrils, red lips swollen & cracked, double vision & tinnitus.	Ataxia, slurred speech, disordered perceptions.	Damage to bone marrow & liver, asphyxiation, convulsions.
Euphoria, kicks sedation.	Constipation, loss of appetite, eyes reddened & watery.	Inattentive, lethargic.	Addiction
Sense alteration, anxiety reduction, sociability, intoxication.	Depression of CNS anesthetic.	Releases aggressive drives, loss of inhibitions.	Damage to liver kidneys & brain Addiction. Potentiates other drugs.
Relaxation, euphoria, kicks, increased ability for performance.	Dizziness, lightness in head, dryness of mouth & throat, irritation of eyes, rapid heart.	Ataxia, hunger, loss of inhibitions, distortion of time & space, periods of fantasy.	Confusion, anxiety, loss of control.
Alertness, activeness, endurance, strength.	Elevated blood pressure, dilation of pupils.	Irritability, irrational, depersonalization, activity increases, nervousness, sleeplessness.	Weight loss, aneurism, elevated blood pressure, toxic psychosis.
Excitation, euphoria, relief of fatigue.	Dilation of pupils, stimulation, loss of appetite, elevation of blood pressure and pulse rate	Talkativeness, hyperactivity, mood alteration.	Toxic psychosis, antisocial acts.
Relaxation	Sedation, drowsiness.	Ataxia, intoxication.	Toxic psychosis addiction.
Reduction of tenseness and anxiety, relaxation.	Sedation	Socialibility, good-humored.	Addiction
Euphoria, kicks, analgesia, sedation.	Constipation, loss of appetite, constricted pupils, slow pulse & respiration.	Calm, inattentive, "on the nod."	Addiction

Although the approach should vary with individuals, several general suggestions seem in order:

- Drug abuse should be handled like any other emotional difficulty in a student; namely, through consultation with school nurse, counselor, psychologist, physician, and parents, in order to identify the source of the problem and obtain professional help. Schools served by a child study team can utilize their consultative expertise.

- The school should adopt a non-accusing, calm, friendly approach to the child (and attempt to convince even the most distraught parents to do the same). In this kind of non-threatening setting, the child may feel freer to disclose his involvement and begin to realize that he will be helped rather than punished.

- The child ought not be pressed for names of friends who are "also using drugs" or for names of drug sources. When a child is ready to give up drugs as a way of life, he will no longer *need* to associate with others of a drug-using life style. He will soon come to reject the street ethic of silence which protects and nurtures those who sell or give drugs to children.

- The complex causes underlying drug abuse call for a number of divergent approaches. Some cases require specialized skills beyond the capacity of the teacher or even that of a child study team. It may be necessary for the school to contact some ongoing referral service such as an ethical community agency equipped to handle children with complex drug problems and behavior. Many of these agencies use trained ex-addicts who serve as sympathetic advisors to parents and school personnel and counselors to students who cannot be reached by other means.

- **No teacher should attempt to diagnose, prescribe, or "treat" suspected cases of drug abuse. This is a task which requires the combined skills of specially trained people.**

- When a teacher is concerned about a child whom he thinks might be involved with drugs, he should refer the case to the appropriate individual, committee or team designated by the school. Referral should be made by competent evaluation of the individual case and preferably accompanied by the mutual consent of the child and his parents.

- In the case of actual referral, it would be in the best interest of the child (possibly parents and school as well) that nothing be recorded on the child's cumulative school or health records.

- A suspected drug abuser must be handled with tact and careful attention to his rights and to the safety and well-being of his schoolmates. Irresponsible acts, however well-intentioned, (in particular, indictment before a child's peers) can cause irrevocable harm to the innocent and may result in a libel suit.

- An uncooperative parent or student will present a real test of the school's philosophical intent. Although this situation occurs quite infrequently, the school should be prepared for it. Since it seems illogical for any institution to underwrite undesirable behavior, it may become necessary for the school to take over the decision-making responsibility. In cases that involve the sale or distribution of drugs to other children, notification of law enforcement authorities may be justified. This de-

cision should be reached only *after all other avenues have been exhausted.*

- Problems of the magnitude described above are seldom if ever resolved by a simple expedient. Expulsion from school, calling in the police, or referral to the courts seeks an easy way out. They are emotional reactions to the problem and avoid the process of deciding logically which action is in the student's interest and welfare. Whether we like it or not, education is involved with the drug problem. The action taken by the school can, in effect, either treat a drug problem or aid in preventing one, depending upon the school's policies in relation to student drug use.

Perhaps if each child can be shown that learning can be exciting, that teachers care, that school is a place where satisfactions can be realized, turning on with drugs will be a thing of the past.

The Parent

Parents, who ought to be the first line of defense in the battle against drug abuse, all too often fail in this most important role.

Let it be made clear at the outset, however, that the use of drugs by a child does not by itself indicate parental neglect, inadequacy or culpability. In fact, parents frequently have done nothing wrong; they have merely been unable to cope with the demands of their children's peer group.

The importance of the peer group is emphasized by recent studies carried out by the Division of Drug Abuse at the New Jersey Medical School in Newark. A comprehensive questionnaire, administered in such a way that anonymity was guaranteed, asked young people why they used drugs. The two reasons listed most frequently were curiosity and pleasure. When the non-using school colleagues of the users were asked about motivation for drug use, they acknowledged the importance of both curiosity and pleasure, but, in addition, indicated that peer group pressure was of equal motivational significance. Further biostatistical studies were then carried out on the first 5,000 students participating in the questionnaire study to determine which of the many factors favoring drug use was most important. By this technique, called multivariate analysis the amount of risk contributed by each factor was assessed. The results were intriguing in that, for all illicit drugs used, the same factor accounted for at least half the total risk: peer group pressure. In other words, if one considered all factors promoting drug use (including, for example, age, sex, familial discord, lack of religious affiliation, sibling drug use, etc.), peer group pressure accounted for at least half of the total risk that can be accounted for; all the other thirty or so variables *together* were not as important as the influence of the peer group.

Even parents who, by all available criteria, would have to be considered as doing an excellent job, are not immune from the spread of serious drug abuse among their children. Often, it is necessary for a physician or minister to convince the parents that self-castigation is not warranted. Indeed, if parents who have little reason for self-blame concentrate on self-evaluation and self-recrimination, they may inadvertently make the situation worse by failing to focus on the real issues.

I do not mean to suggest that parents are ordinarily blameless; frequently they are not. There is little doubt that children brought up in an unhappy home are more prone to succumb to the blandishments of the peer group. And Dr. Richard Blum of Stanford has adduced evidence that drug abuse is more prevalent among those who brought to parents personal problems that were then not resolved to the satisfaction of the child. When such problems remain

unresolved, they fester, and as a derivative phenomenon, the youngster is made more susceptible to involvement in the drug scene.

We have found in our studies (as have Richard Blum in California and Reginald Smart in Toronto) that the drug use patterns of the parents influence the behavior and attitudes of the children towards drug use.

If parents use tranquilizers or sedatives on a regular basis, this use increases the risk of their children's using illicit drugs by 2-to-3-fold. Similarly, if a parent smokes a pack or more of cigarettes per day, this increases the risk of illicit drug use by their children by 2-to-3-fold.

Interestingly, despite the oft-heard "You have your booze, let me have my pot" assertion by many youngsters, questionnaire results failed to show that moderate use of alcohol by parents influences the drug use patterns of their children. I would emphasize that these studies are based on questionnaires to students and so represent the students' perceptions of the parents' drug use. Further studies assessing the accuracy of these perceptions are now under way.

So parents can, to some extent, influence their children's drug use behavior if they will merely limit their own drug taking. There are other obligations for parents, aside from setting a good example.*

First, it is imperative that parents acquire knowledge. Perhaps there is no single defect as striking as the failure of parents to educate themselves. Listening to lectures, watching motion pictures, participating in group discussions, reading short brochures, these are just not adequate. Parents must be willing to read at least one book or more that adequately and dispassionately reviews the drug scene in reasonably comprehensive fashion. Surprisingly, it is relatively easy to acquire the basic knowledge necessary to begin to cope intelligently with the drug scene.

Second, parents must be willing to assess carefully the motivation of their children for drug use, as well as the extent of use. All too often parents react either with panic or insouciance, instead of analyzing the situation in unemotional fashion. Thus, for example, it makes a tremendous difference if the reason for use is, on the one hand, curiosity or, on the other, psychological abnormality. This can be illustrated by the following case history:

A suburban 17-year-old was referred because he was a heavy heroin user. His mother had made the assumption that he was a frivolous, irresponsible youngster who had started with marijuana and then, for purely selfish, hedonistic purposes, graduated to heroin. On questioning, the boy admitted to use of marijuana, barbiturates and heroin, but he specifically denied use of LSD, oral amphetamines or intravenous methamphetamine. This is such an unusual pattern in suburbia that it prompted further questioning about his motivation. It turned out that the boy suffered from an overwhelming identity crisis which provoked a profound depression that took the form of agitation. In an attempt to cope with the agitation, he resorted to marijua-

*In my recent book, *Overcoming Drugs*, (McGraw-Hill, 1971) I have formulated a detailed program for parents. The reader seeking more extensive information in this area is referred to Chapter 4 in that book.

na, sedatives or heroin, each of which has the capacity to mitigate anxiety. The parents refused even to consider that an identity crisis—rather than curiosity, affluence or pleasure-seeking—was responsible for their son's deep involvement in the drug scene.

Other important motivations for drug experimentation include boredom and loneliness. The latter is of enormous importance; many of those who have been through the drug scene will acknowledge that loneliness was the major motivating force propelling them to multiple drug use. Frequently, the parent is faced with an unpleasant alternative—whether to permit a lonely child to participate in the activities of a peer group known to be experimenting with drugs, or to forbid such participation, knowing that this will ineluctably increase the child's loneliness (and may subsequently contribute to an even greater drug problem as an escape from loneliness).

The studies on motivation have been done, for the most part, on students age 14 and older. However, the motivation for use appears to be similar for those in grade school and junior high school. Curiosity and peer group influence are still of immense importance. In addition, the younger the child, the greater the impact of sibling drug use patterns. For example, if an older sibling, especially one of the same sex, uses marijuana, this markedly increases the likelihood of illicit drug use in the younger sibling(s).

Not only must the parents decide the motivation behind drug use, but they must also carefully consider the drug involved and the frequency of use. There is an enormous difference between ephemeral experimentation with marijuana because of peer group pressure, and experimentation with LSD, heroin or intravenous methamphetamine. Similarly, a child who uses marijuana once a month or less is very different from one who smokes the drug weekly or daily. The latter is far more prone to escalate to more dangerous mind-altering agents (such as LSD).

Thus, motivation for use, the state of the child's personality, the nature of the drug, and the frequency of use are all important and interrelated variables. If parents disregard these variables and view drug use in monolithic fashion, they will not be able to cope with the problem in their families or communities.

The Teacher

The role of the teacher in drug abuse has never been adequately defined—in large part because the teacher has been used primarily as an arm of the administration in the area of detection. Consequently, the teacher is ordinarily viewed by the students in a punitive role. Most teachers, disliking this role and not feeling equipped by training to handle the drug scene competently, have elected to adopt a simplistic view of drug abuse. They react either repressively or insouciantly to drug use among their students. Other teachers adopt a pejorative approach to the whole drug scene and seem primarily interested in ascertaining their legal responsibilities and nothing more.

There are several points that must be emphasized in regard to teachers:

- Teachers, like parents, cannot deal with this problem in ignorance. Yet, unfortunately, the majority of teachers have not yet undertaken the requisite self-education.

Students can hardly respect their views if the teachers' statements and feelings remain unbuttressed by knowledge about the drug scene. Part of this failure of self-education results from a fear that those they are trying to educate are in actuality far more sophisticated and knowledgeable about

the drug scene. This need not be so. Our studies show that students know appallingly little about the drugs they discuss, take or sell.

- Any teacher willing to read a few books will know substantially more of the facts about drugs than the overwhelming majority of the students.

- Teachers must begin by divesting themselves of stereotypes about the drug user. Too often, drug taking is considered to be the behavior pattern of certain minority groups and so-called "hippies." This of course is nonsense; drug abuse has diffused so widely throughout our society that it may involve *any* young person.

- Each teacher might do well to ask himself whether what is being taught bores his pupils. I do not ask that there be a dramatic change in curriculum. But it is unfortunately true that much teaching is done in unnecessarily dull fashion and boredom within the classroom is a contributor to the restlessness in which drug experimentation occurs.

- The teacher often becomes aware that a student is getting into trouble with drugs, and the question arises as to how the teacher should best handle this problem vis-a-vis the parents. Parents frequently refuse to accept the reality of their child's involvement with illicit drugs; some react indifferently, others refuse to consider the teacher's information, and still others react with rage against the school or, more frequently, the child. Only a minority react calmly and rationally. Consequently, the teacher does best to avoid a direct disclosure or confrontation with the parents. Instead, the child should be referred to a counselor or the appropriate school health person. Alternatively, if the school is fortunate enough to have an ombudsman, the problem can be turned over to him. My definition of an ombudsman is a teacher who has a record of relating well to students in a confidential, avuncular manner* and who has taken some additional training in drug problems. The ombudsman or counselor may choose to involve the parents or perhaps to handle the problem with the student alone without parental involvement. Obviously, what is done in relation to the parents will vary from case to case and it would be imprudent to formulate a rigid, monolithic course of action. If the parents are inordinately negative and hostile, their attitude will only exacerbate the problem. The teachers and the school ought to encourage reading on drug abuse by the parents, for the more they know about the drug scene, the less likely they will be to react in an irrational and potentially destructive fashion.

- Teachers have a particular responsibility to insure that extracurricular school programs are available and that they are constructive and exciting for the students. With increasing financial pressures, schools tend to restrict extracurricular programs. This is, of course, disastrous as far as the drug scene is concerned.

The Community

The community has an enormous responsibility in regard to the drug scene. I have detailed this elsewhere** and will briefly discuss only three points here. First, it is the community's obligation to make sure it has in its local library adequate information on the drug scene, and that parents are made aware of the availability of such reading materials.

Second, and most important of all, the community must take steps to alleviate boredom among its young

*See *Overcoming Drugs*, Chapter 5.

**Ibid*, Chapter 6.

people. There are just too many young persons who have too little to occupy them. And young, intrinsically energetic persons who are bored are very likely to get swept up in the drug scene. This should be perfectly obvious, yet communities appear almost unwilling to take appropriate and effective action in this area. They would rather attack their drug problem by going after the drugs themselves, when they should instead be providing viable alternatives to drug experimentation.

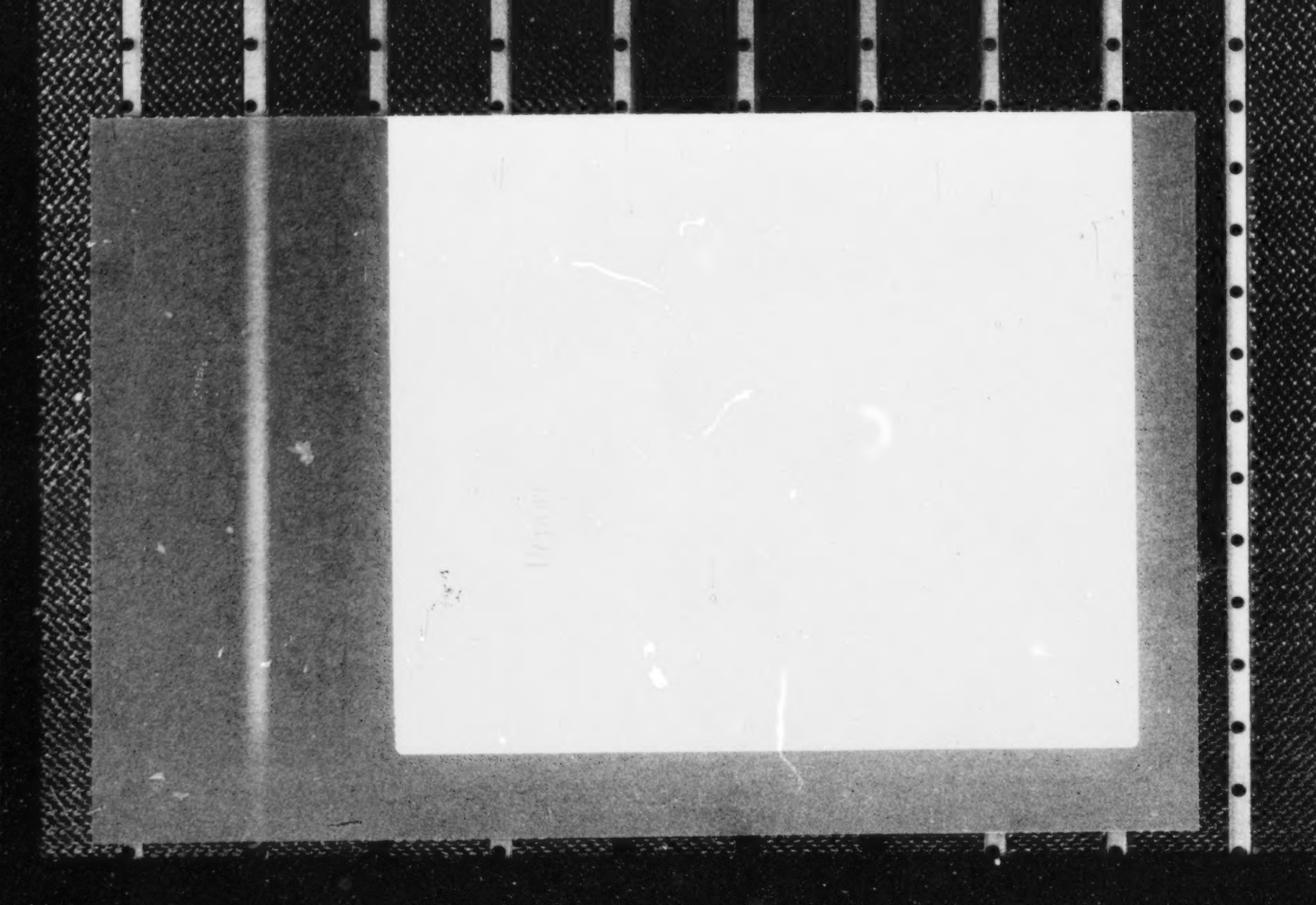
Very few communities have taken a hard look at themselves to determine just what is available for young persons and what are their unmet needs. Many make the assumption they have adequate youth activities but have neither consulted their youth nor looked at specific activities to assess their efficacy. Frequently, programs that appear to be valuable after superficial examination, turn out, on closer analysis, to be dull, ineptly supervised or anachronistic. In some cases, communities decided that far too little was being done and constructed new facilities—only to realize that no responsible young people had been brought into decision-making roles. Thus, despite impressive-appearing facilities, they found themselves with massively under-utilized programs.

Part of the problem is that many communities are unwilling to spend tax dollars on such projects. Some will insist they cannot offer a broad array of opportunities for young persons. Ridiculous. Any community can formulate a plethora of potentially worthwhile programs—athletic programs, anti-pollution projects, art or theatrical endeavors, hospital work, tutoring of retarded children—to name just a few.

Any community that will not undertake to provide young persons with exciting programs offering them continuing involvement is at risk in regard to drugs.

Third, the community should, in constructive fashion, help evaluate the classroom and extracurricular programs within the school system to ensure that, insofar as possible, the school activities are vital and interesting to the students. This will require a form of classroom monitoring that, of course, must be conducted in a thoughtful way with impeccable manners—and it must be done with the collaboration of the teachers.

Clearly, there is no monolithic approach to the drug problem. For too long, parents, teachers and community leaders have gone their separate ways without adequate coordination. This cannot continue; drug abuse is a problem that impinges on home, school and community simultaneously. Unless there is a continuing interaction among the three, the problem will continue to plague our society. Conversely, if all segments of society approach the problem in comprehensive and dispassionate fashion, it should be possible to control and then substantially reduce the severity of this national epidemic.



Introduction

On January 11-12, 1971, the Office of Child Development and the Office of the Assistant Secretary for Health and Scientific Affairs, U.S. Department of Health, Education, and Welfare, called a conference to discuss the use of stimulant medications in the treatment of elementary school-age children with certain behavioral disturbances. In convening the conference, the Office of Child Development was aware of public concern about the increasing use of stimulant medications (such as dextroamphetamine and methylphenidate) in treating so-called hyperkinetic behavioral disorders. Were these drugs—so widely misused or abused by adolescents and adults—truly safe for children? Were they properly prescribed, or were they used for youngsters who, in fact, need other types of treatment? Is emphasis on medications for behavioral disorders misleading? Might this approach tempt many to oversimplify a complex problem, leading to neglect of remedial social, educational, or psychological efforts on the part of professionals, parents, schools, and public agencies?

In order to clarify the conditions under which these medications are beneficial or harmful to children, to assess the status of current knowledge, and to determine the best auspices for administering these drugs to children, a panel of 15 specialists was invited to meet in Washington, D.C. The panelists were from the fields of education, psychology, special education, pediatrics, adult and child psychiatry, psychoanalysis, basic and clinical pharmacology, internal medicine, drug abuse, and social work. The panel's task was to review the evidence of research and experience and to prepare an advisory report for professionals and the public.

This report briefly outlines the general nature of behavioral disorders in children and then focuses on those disorders that are being treated with stimulant medications. It discusses appropriate treatment and the concerns voiced by the public and the media. Finally, the report examines the role of the pharmaceutical industry, professionals, and the news media in publicizing stimulant drugs for children and outlines the glaring gaps in needed research, training and facilities.

Behavioral Disorders of Childhood

A wide range of conditions and disabilities can interfere with a child's learning at home and in school, his socialization with peers, and his capacity to reach his maximum development. Social deprivations and stress at home or school may retard optimal development. Mental retardation, the more rarely occurring childhood autism and psychosis, and other such disabilities may cause serious problems. Some difficulties arise because of clearly definable medical conditions such as blindness, deafness, or obvious brain dysfunction. Some are associated with specific reading or perceptual defects, and others with severe personality or

emotional disturbance.

Such dysfunctions are known to require careful evaluation, thoughtfully planned treatment employing a variety of methods on the child's behalf, and conscientious monitoring of remedial treatments. Individualized evaluation and treatment are important for any childhood behavioral disorder. There are appropriate occasions for use of medications such as tranquilizers and anti-depressants in some children with these disorders. For over three decades, stimulant medications have been selectively used for children under medical supervision. We now focus on issues related to the current use of these drugs.

Hyperkinetic Disorders

The type of disturbance that has evoked misunderstanding and concern has many names. The two most familiar terms—neither entirely satisfactory—are *minimal brain dysfunction* or, more commonly, *hyperkinetic behavioral disturbance*. There is no known single cause or simple answer for such problems. The major symptoms are an increase of purposeless physical activity and a significantly impaired span of focused attention. The inability to control physical motion and attention may generate other consequences, such as disturbed mood and behavior within the home, at play with peers, and in the schoolroom.

In its clear-cut form, the overt hyperactivity is not simply a matter of degree but of quality. The physical activity appears driven—as if there were an "inner tornado"—so that the activity is beyond the child's control, as compared to other children. The child is distracted, racing from one idea and interest to another, but unable to focus attention.

Incidence of Hyperkinetic Disorders

This syndrome is found in children of all socioeconomic groups and in countries throughout the world. A conservative estimate would be that moderate and severe disorders are found in about 3 out of 100 elementary school children—an estimate that would vary somewhat in different communities. More males than females are affected, as is true in a number of childhood ailments. Children so afflicted are generally of normal or superior intelligence. A significant number so diagnosed have special learning or reading disabilities, in addition to the major symptoms. A near majority are reported to have had behavioral problems since infancy. There is a smaller group of more severely afflicted children upon whom studies have focused; they may show increased clumsiness and a variety of physical symptoms. Thus, some of the children show hyperactivity and reduced attention that range in degree from mild to severe, with or without associated physical signs of special learning impairments; some have complex behavioral and personality problems, as well as special learning and reading difficulties, along with the major hyperkinetic symptoms.

Causes of Hyperkinetic Disorders

We know little about definitive causes. The disorder has been ascribed to biological, psychological, social, or environmental factors, or a combination of these. There is speculation that the core set of symptoms—those affecting control of attention and motor activity—may have their origin in events taking place before the child is born, or during the birth process, or they may be related to some infection or injury in early life. The neurological and psychological control of attention is an important but incompletely researched topic, as are the nutritional, perinatal, and developmental factors. Thus, in many instances, it is not yet possible even to speculate as to original causes.

The Course of Hyperkinetic Disorders

Usually, the excessive activity and attentional disturbances are less apparent after puberty. Specialists citing

experience and some fragmentary research data believe that treatment enables many to lead productive lives as adults, while severely afflicted children who remain untreated may be significantly at risk for adult disorders. Extensive research is still required on these points. Because the ages of 5 to 12 are crucial to the child's development and self-image, treatments that permit the child to be more accessible to environmental resources are warranted and useful.

Diagnosis of Hyperkinetic Disorders

In diagnosing hyperkinetic behavioral disturbance, it is important to note that similar behavioral symptoms may be due to other illnesses or to relatively simple causes. Essentially healthy children may have difficulty maintaining attention and motor control because of a period of stress in school or at home. It is important to recognize the child whose inattention and restlessness may be caused by hunger, poor teaching, overcrowded classrooms, or lack of understanding by teachers or parents. Frustrated adults reacting to a child who does not meet their standards can exaggerate the significance of occasional inattention or restlessness. Above all, the normal ebullience of childhood should not be confused with the very special problems of the child with hyperkinetic behavioral disorders.

The diagnosis is clearly best made by a skilled observer. There, unfortunately, is no single diagnostic test. Accordingly, the specialist must comprehensively evaluate the child and assess the significance of a variety of symptoms. He considers causal and contributory factors—both permanent and temporary—such as environmental stress. He distinguishes special dysfunctions such as certain epilepsies, schizophrenia, depression or anxiety, mental retardation or perceptual deficiencies. The less severe and dramatic forms of hyperkinetic disorders also require careful evaluation. Adequate diagnosis may require the use not only of medical but of special psychological, educational, and social resources.

Treatment Programs

The fact that these dysfunctions range from mild to severe and have ill-understood causes and outcomes should *not* obscure the necessity for skilled and special interventions. The majority of the better-known diseases —from cancer and diabetes to hypertension—similarly have unknown or multiple causes and consequences. Their early manifestations are often not readily recognizable. Yet useful treatment programs have been developed to alleviate these conditions. Uncertainty as to cause has not prevented tests of the effectiveness of available treatments, while the search for clearer definitions and more effective kinds of therapy continues. The same principles should clearly apply to the hyperkinetic behavioral disorders.

Several approaches now appear to be helpful. Special classes and teachers can be directed to specific learning disabilities and to restore the confidence of the child who experiences chronic failure. Modification of behavior by systematic rewarding of desired actions has been reported to be useful in some children. Elimination of disturbing influences in the family or classroom through counseling may often tip the balance, and a happier child may show improved control and function.

There will be children for whom such efforts are not sufficient. Their history and their examination reveal symptoms of such a driven nature that skilled clinicians should undertake a trial of medical treatment. Medicine does not "cure" the condition, but the child may become more accessible to educational and counseling efforts. Over the short term and at a critical age, this can provide the help needed for the child's development.

Stimulant medications are benefi-

cial in only about one-half to two-thirds of the cases in which trials of the drugs are warranted. The stimulant drugs are considered to be the first and least complicated of the medicines to be tried. Other medications—the so-called tranquilizers and antidepressants—are generally reserved for a smaller group of patients. Without specialized medical therapy, the consequences for these children of their failure to manage—even in an optimal environment—are clearly very severe. In such cases, the aim is not to "solve problems with drugs" but to put the severely handicapped child in a position to interact with his environment to the extent that his condition permits.

Response to stimulant medication cannot be predicted in advance. Fortunately, the issue can be resolved quickly. When stimulants are given in adequate doses, a favorable response—when it occurs—is fairly rapidly obtained and is unmistakably the consequence of the drug. Thus, if an adequate test of pharmacotherapy (for a period of a few days or weeks) produces only doubtful benefits or none at all, treatment can be promptly terminated. The physician will, of course, adjust dosage carefully to assure an adequate therapeutic trial. It would be tragic to deprive a child of a potentially beneficial treatment by inattention to dose. Thus, it is clear that not all affected children require medication and that of those who do, not all respond.

When the medication is effective, the child can modulate and organize his activities in the direction he wishes. The stimulant does not slow down or suppress the hyperkinetic child in the exercise of his initiative. Nor does it pep him up, make him feel high, overstimulated, or out of touch with his environment. Much has been made of the "paradoxical sedative" effect of stimulants in such children. The term is inappropriate. Although their exact mechanism of action is not known, stimulants do not provide a chemical straitjacket. They do not act as a sedative. Rather, they appear to mobilize and to increase the child's abilities to focus on meaningful stimuli and to organize his bodily movements more purposefully.

The hoped-for secondary consequences are better peer relationships, improved self-image, and pleasure in acquiring competencies. Any coexisting dysfunctions—such as special perceptual and learning handicaps—must not be left unattended, simply because pharmacotherapy is available and sometimes helpful. Similarly, personality and psychological problems, social and family problems, may require continued attention.

During drug treatment, the dosage may require shifting to minimize unwanted effects, of which the major ones are loss of appetite and insomnia. Drug treatment should not and need not be indefinite and usually is stopped after the age of 11 or 12. Frequently, following a sustained improvement over several months or a year or so, drugs may be discontinued, as during a vacation period. Drug-free intervals can be prolonged as observers assess the child's condition.

The decision to use drug treatment thus depends on the commitment to diagnose and to monitor the response to treatment in the best traditions of medical practice. When there is informed parental consent, parents, teachers, and professionals can collaborate in organizing and monitoring treatment programs.

Concerns Raised by the Public and the News Media

We will now turn to various concerns about hazards and abuses when stimulant medications are used for children. For example, concern has been expressed that the medical use of stimulants could create drug dependence in later years or induce toxicity. This subject touches on the rights of the child to needed treatment, as well as risks to both the child and the public, and requires continued intensive scrutiny.

1. *Does the medication produce toxicity?* One should not confuse the effects of intravenous stimulants and the high dosages used by drug abusers with the effects or the risks of the low dosages used in medical therapy. In the dosage used for children, the questions of acute or chronic toxicity noted in the stimulant abuser are simply not a critical issue. Unwanted mental or physical effects do rarely appear in children; cessation of therapy or adjustment of dosage quite readily solves the problem.

2. *Is there a risk of drug dependence in later years?* Thirty years of clinical experience and several scientific studies have failed to reveal an association between the medical use of stimulants in the pre-adolescent child and later drug abuse. Physicians who care for children treated with stimulants have noted that the children do not experience the pleasurable, subjective effects that would encourage misuse. They observe that most often the child is willing to stop the therapy, which he views as "medicine." Thus, the young child's experience of drug effects under medical management does not seem to induce misuse. The medical supervision may "train" him in the appropriate use of medicines. When adults are given stimulants—or even opiates—for time-limited periods under appropriate supervision and for justifiable reasons, there is relatively little misuse. Similarly, in treating epilepsy, barbiturates have been given from infancy to adulthood without creating problems of dependency or abuse.

It is not ordinarily the drug that constitutes abuse but the way in which a drug and its effects are used and exploited by an individual. There are indeed adolescents who, in varying degrees and for varying periods of time, either misuse or dangerously abuse stimulants. They experiment with the effects of excessive dosages to create excitement, to avoid sleep, to defy constraints, and to combat fatigue and gloom. It should be noted that these drugs are not commonly prescribed to children after the age of 11 or 12, when the actual risks of such experimentation or misuse might possibly become more significant.

Alert monitoring of drug use at any age is a part of sensible medical practice. With such precaution and with the available evidence, we find minimal cause for concern that treatment will induce dangerous drug misuse. To the contrary, there are very good reasons to expect that help, rather than harm, will be the result of appropriate treatment.

3. *Are there safeguards against misuse?* There are some sensible steps, in addition to medical control, that guard against possible misuse. The child should not be given sole responsibility for taking the medication. He usually need not bring the drug to school. The precautions that surround the medicine cabinet—whether it contains antibiotics, aspirins, sedatives, or other medications—should be applied. Many such medicines, when misused, can be more dangerous to health and life than even the stimulant drugs. No child in the family should have access to medications not prescribed for him. These are general precautions that are a part of the child's education in the "etiquette of the medicine cabinet."

4. *Do stimulants for children create a risk for others?* The panel agrees that stimulant drug abuse is seriously undesirable and frequently dangerous, although views vary on the scope of the problem and the number of actual casualties. Experts also agree that far more stimulants are prescribed for adults than are medically needed and far more are manufactured than prescribed. Overprescription of any medication is deplored, whether or not it is liable to abuse. The question is whether the availability of stimulants for a very few of the childhood behavioral disorders threatens the public health.

The prescribed dosage for an individual child constitutes an insufficient quantity to supply the confirmed abuser of stimulants with the amounts he

requires. It is also true that illicitly manufactured stimulants are quite readily available and abused in this country. We must weigh the advantages of having appropriate medication available against the dangers of withholding treatment from a child who can clearly benefit from it. We doubt that prescriptions for the children who benefit from stimulants will require the manufacture of excessive and dangerously divertible supplies. With sensible precautions, there is at present no evidence justifying sensational alarm, either about the safety of the individual child who can benefit from therapy or about the safety of the general public.

5. *Does medication handicap the child emotionally?* It is sometimes suggested that treated children may not be able to learn normal responses and to master adjustments to the stresses of everyday life. These fears are understandable but are not confirmed by specialists who have experience with the conditions and the situations in which medications are properly used. For the correctly diagnosed child, these medications—if they work at all—facilitate the development of the ability to focus attention and to make judgments in directing behavior. Such children can acquire the capacity to tolerate and master stress. The medications, in these circumstances, help "set the stage" for satisfactory psychological development.

The hyperkinetic behavioral disturbance is a form of disorganization that creates great stress in the afflicted child. The use of therapeutic stimulants for this disturbance should not be equated with the misuse of medication aimed at allowing a normal child or adult to avoid or escape the ordinary stresses of life.

6. *What are the rights of the parents?* Under no circumstances should any attempt be made to coerce parents to accept any particular treatment. As with any illness, the child's confidence must be respected. The consent of the patient and his parents or guardian must be obtained for treatment. It is proper for school personnel to inform parents of a child's behavioral problems, but members of the school staff should not directly diagnose the hyperkinetic disturbance or prescribe treatment. The school should initiate contact with a physician only with the parents' consent. When the parents do give their approval, cooperation by teachers, social workers, special education and medical personnel can provide valuable help in treating the child's problem.

Stigmatizing the Medicines and Children, and the Role of Public Education

A child who benefits from stimulants or other psychotropic medications should not be stigmatized; his situation is no different from that of the child who benefits from eyeglasses. It is unjust to stigmatize a child in later life, when competing in various situations (applying for college, employment, or organization memberships), by labeling him early in life as "stupid," an "emotional cripple," a "drug-taker," or by any other kind of unjustified and unfortunate stereotype.

Nor should the medicine be stigmatized. Where bad practices prevail—and a number of complaints have been called to our attention—these practices should be squarely dealt with. This is not only a responsibility of physicians and educators but also of the news media. Yet indignation must be tempered with perspective and scrupulous respect for the facts. An informed and understanding public can foster the growth and development of children, and these public attitudes may lead to the development of more refined and better-delivered health services. Either bad practices or exaggerated alarm can threaten the availability of medical resources for those who critically need them. This has happened before in the history of valuable medicines, and it could take years to repair the damage.

The Promotion of Drugs by Industry and the Media

Pharmaceutical companies producing stimulants or new medications that may become useful for hyperkinetic disorders have a serious obligation to the public. These medicines should be promoted ethically and *only* through medical channels. Manufacturers should not seek endorsement of their products by school personnel. In the current climate, society can best be served if industry refrains from any implicit urging that nonspecialists deal with disorders and medications with which they are unfamiliar. Professionals and the news media can play useful roles by not pressing for treatments in advance of their practical availability.

The Delivery of Special Health Care: A Dilemma

Our society has not as yet found complete solutions to the problem of the delivery of special health care. When available treatments cannot be confidently and appropriately delivered by physicians, they are perhaps best withheld until such treatments can be provided—especially with milder dysfunctions. This is not to say that severely afflicted hyperkinetic children should not or cannot receive available medical treatment. But until systems of continuing professional education and ready access to consultants are financed and perfected, some judgment about the pace at which unfamiliar treatments can be widely fostered is required. Finally, we must recognize that it is not only the scarcity of trained personnel but factors such as poverty and inadequate educational facilities that prevent accessibility to individualized treatment.

The Need for Skills and Knowledge

In preparing this report, the panel was repeatedly struck by our lack of information in many crucial areas. The facts are that children constitute well over half our population but receive a disproportionately low share of skilled research attention. We have noted the difficulties in arriving at accurate methods of diagnosis and the importance of launching careful longitudinal and follow-up studies. The investigation of causal factors lags. Such factors as perinatal injury, environmental stress, or the development of the neurological and psychological controls of attention require study. Variations in different socioeconomic and ethnic groups must be considered in order to arrive at better definitions of behavior properly regarded as pathological. All such research efforts would have aided us in assessing the numbers of affected children and in recommending designs for more effective treatment programs.

Clinical pharmacologists have repeatedly found that drugs may act differently on children than on adults. To use medicines of all kinds effectively on children, more specialists must be trained in drug investigation—for example, pharmacologists who can develop basic knowledge about the action of drugs in the developing organism. There is the obvious need for better and more precisely targeted drugs for the whole range of severe childhood behavior disorders. This requires intense research and training efforts. Such efforts provide the means for developing, testing, and delivering better treatment programs. There is a similar need for research in the techniques of special education and also a need to make these techniques available to children who can benefit. It would appear to be a sound federal investment to conduct such research and training.

In summary, there is a place for stimulant medications in the treatment of the hyperkinetic behavioral disturbance, but these medications are not the only form of effective treatment. We recommend a code of ethical practices in the promotion of medicines, and candor, meticulous care, and restraint on the part of the media, professionals, and the public. Expanded

programs of continuing education for those concerned with the health care of the young, and also sustained research into their problems, are urgently needed.

Our society is facing a crisis in its competence and willingness to develop and deliver authentic knowledge about complex problems. Without such knowledge, the public cannot be protected against half-truths and sensationalism, nor can the public advance its concern for the health of children.

Participants in the Panel

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Afterwords

Drug-Mediated Behavior Controls: Concerns and Criticism

Arnold Arnold
Author, Newspaper Columnist

There seems to be a dangerous trend in the scientific and educational community towards a technological pollution of the decision-making process. This can have a profoundly damaging effect on public policy and on community attitudes. It is irresponsible when scientists foul the stream of information merely to vindicate their preoccupations, or to assure themselves of research support. In such instances we must be especially conservative about the general application of a technology about which considerable uncertainty exists as to its social and physical side-effects, when there is a high probability

of misinformation, misinterpretation, and misuse, insufficient practical expertise and a lack of data.

The use of drugs in treating the symptoms of hyperkinesis and minimal brain dysfunction (MBD) in prepuberty children is only a single factor in a much larger problem to which those who concern themselves with childhood, education and the diagnosis of behavior and learning problems must address themselves.

I agree with the Freedman committee report[1] insofar as responsible research, careful diagnosis and discreet prescription of particular drugs are concerned. But this report must be read and understood in the context of a present-day environment that forces increasing numbers of children into hyperactive behavior.

Lack of urban play spaces, crowded or isolated living conditions, inadequate schools, hard-pressed teachers, inattentive, uncommunicative and deprived families are symptomatic of our time. They tend to foster misinterpretation of the symptoms of hyperactivity in children that have nothing to do with MBD. For example, Freedman et al. do not question whether the *amount* of time spent before the TV set daily might not, in itself, be one cause of hyperactivity in many children. Graven and Narkewicz[2] have found symptoms, due to TV addiction, similar or identical to those commonly attributed to MBD.

The core questions evaded by the Freedman committee are: What can be done to prevent the spread of drug-mediated behavior controls applied to children who fail to adapt to a child-hostile environment, or who fail to learn in schools that recognize none but a single institutionalized intelligence?

How can we ameliorate environmental conditions that escalate psychological and perceptual disturbances and learning failures in children? These main concerns do not exclude drug intervention in those relatively rare cases when careful diagnosis by competent medical experts indicates a need. But a preoccupation with, or major reliance on, drug intervention may accelerate a deteriorating climate at home, in the classroom and in our society at large.

The Freedman committee claims to be limited by a special mission. Yet it was convened to answer public questions and concerns and to provide guide lines for professionals in medicine and education. The very term "minimal brain *dysfunction*" is popularly misunderstood and used interchangeably with "minimal brain *damage*." There is no discernible physiological symptom, except in the rarest cases, associated with hyperkinesis at the present state of the art. Further, association of reading difficulties with hyperkinesis has led to conclusions that MBD is related to "dyslexia."[3] But a 1968 HEW Secretary's committee on reading failure, after a year's study and an expenditure of $145,000, was unable to agree even on a definition of the term "dyslexia." The Freedman committee report fails to address itself to diagnostic misconceptions to which many psychologists, pediatricians and other professionals subscribe.

The Freedman committee played a numbers game that has contributed to confusion, rather than a clarification of the problem of MBD. It concludes that perhaps 3 percent of the pre-puberty child population could be considered hyperkinetic. It suggests that an *undisclosed fraction* of this percentage suffers this condition due to other than environmental causes, but that only one-

third to two-thirds of this *fraction* responds favorably to Ritalin, amphetamines and related drugs.

With about 4 million children at each age from six through eleven there would, according to the committee's estimate, be no more than 720,000 U.S. children at any one time who suffer such symptoms, of whom perhaps 480,000 might suffer MBD, if a one-third of two-thirds relationship is hypothesized. Again, using the committee's own projections, no more than 160,000 to 320,000 of these children could possibly benefit from drug intervention. Yet, according to NIMH estimates, between 200,000 to 300,000 prepuberty children are already on such drug regimen, though this practice is presently restricted to a very few localities in the U.S.

The Freedman committee's numbers game lends respectability, for example, to the *Wall Street Journal* claim that ". . . many doctors now argue, the real problem may be that too few children in need of amphetamine therapy receive it. The NIMH . . . estimates that upward of 200,000 children in 1969 were taking amphetamines for hyperactivity. That's only about 10% of the estimated two million hyperactive youngsters who need help among the nation's 28 million elementary school children."[4] This would represent a 22 million dollar annual bonanza to the drug industry. The Freedman committee could also be construed to support the view of Dr. Herbert Krugman et al, who wrote in the *Public Opinion Quarterly* that "The time may come, when the mass media may create special (subliminal) programs to help people modify certain attitudes and behavior . . . For early childhood education there is the opportunity to accept the fact that many children fidget in class . . . Mild drugging of these children . . . may be helpful to their educational achievement."[5]

The Wall Street Journal found vindication of its position in the Freedman committee report, in an article subsequent to its release, and the AP placed a similar construction on it. It may also have affected Dr. S.P. Marland, U.S. Commissioner of Education. In an ambiguous statement before Congress, during his presentation of USOE's 1972 budget, Dr. Marland asked for an expanded use of educational technology that rests on a foundation of "Sesame Street" type of TV programming and "it could be with drugs."[6] I asked Dr. Marland three questions about these statements and for clarification of exactly what he meant by "it could be with drugs." He answered my "Sesame Street" question, but refused to say whether he was referring to "drug abuse education" or to "drug aided education or drug modification of behavior."

The U.S. Attorney General's Office and other branches of the Federal Government are equally infatuated with technological answers to social and behavioral questions. They range from suggestions that preschool children be screened for delinquent tendencies and that those found "prone" be treated with drugs, to electronic implants in the brains of criminals.

The Freedman committee deplores the shortage of qualified medical experts and it pleads for what can (and should) be construed to mean diagnosis of MBD by a team of experts. But it has nothing to say about the many unqualified physicians who presently make these diagnoses, or about the requirement that a pediatric neurologist should be a member of the diagnostic team. It avoided this latter suggestion because it knew full well that there are only about 100 pediatric neurologists in the U.S. and that this is an insufficient number to guarantee every suspected sufferer the proper diagnosis.

Which and whose children does the Freedman committee really talk about? Does it address itself to the problem of middle-class and upperclass hyperkinetic children for whom proper diagnostic facilities exist, at least in some parts of the U.S.? Do its concerns

extend to poverty children—the blacks, Puerto Ricans, Chicanos and Indians—among whom a 30 percent incidence of hyperkinesis and MBD are postulated by some proponents of massive drug intervention? Proper diagnostic facilities are certainly not available to them. Yet there is ample evidence that when poverty children are nurtured and encouraged in considerate preschool and elementary grades classrooms such symptoms are relieved or disappear entirely as they learn to trust, to cope and acquire controls and skills.

The great temptation is, as a result of the ambiguities in the Freedman committee report, to expand the use of drugs to control poverty children so as to make them amenable to rote learning that prepares them for minimal skills—menial work and the ability to take rifles apart—instead of providing a proper social and learning environment. There is some evidence that this is now the underlying philosophy of the U.S. Office of Education. It is an extension of the Jensen-Herrnstein-Shockley[7,8,9] myth that poverty children are innately inferior, ineducable and badly behaved.

Finally, there is the real threat that drugs designed to assist learning and memory will be peddled during the next decade or two with the same disregard for children, lack of research, lack of data, and a lack of consideration of pharmacological and social side effects and without adequate diagnostic facilities, as are behavior modifying drugs today in many instances. And so my objections to the Freedman committee report are based less on what it states and more on what it leaves out and evades, on its lack of candor and clarity that lends itself to a rationalization of social irresponsibility for the sake of a claimed, but dubious technological efficiency.

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In Answer to Mr. Arnold

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It is rare that one is asked to write a commentary on a commentary. However, this critique of Arnold Arnold's critique of the report of the "Conference on the Use of Stimulant Drugs in the Treatment of Behaviorally Disturbed Young School Children" stems from the concerns expressed by a number of our respected colleagues from a range of disciplines.

They have felt that a scholarly, sound and single-purpose study which carried out the mission assigned to it, was taken to task by Mr. Arnold because it addressed itself only to that mission and not to the ills of society.

It is easy to be in sympathy with Mr. Arnold's point of view until one matches it with both the report and the references he uses as authorities for his specific complaints about it, and in general about the use of medications which can help hyperactive children. For example, the conference was not directed to be concerned with "massive drug-mediated behavior controls" (Arnold) which is then criticized as an evasion without finding out what the conference was specifically instructed to consider. From there Arnold's critique goes on to systematically misinterpret, exaggerate and make assumptions in order to validate his points—beginning with his use of Graven and Narkewicz's study on the results of TV addiction. The children who are truly the hyperactive ones, who are born with motors that race very easily and who have poor brakes, by definition cannot sit and attend to TV to the point of "addiction."

The "Freedman report" is accused of a "numbers game" which Arnold proceeds to play himself without following the rules for accuracy. For example, he uses a reporter's interpretation in the newspaper article he quoted about 2 million U.S. pre-puberty children benefiting from drug-mediated behavior control, based on figures which the authorities quoted say are inaccurately reported and which he did not check. Also, on close examination the article does not say that at all. Rather, it says that all these hyperactive children need help, but also points out later that only a segment of them can benefit from medication.

In the testimony by Dr. Marland quoted by Arnold to make his points, when comparing it with the original from the Congressional Record, one finds that drugs are mentioned as part of a question about television in childhood education. In response to a check on what was meant, an official reply from the Office of Education indicates that drugs were mentioned in the context of the use of television for drug abuse education for older school children and their families. Dr. Marland says nothing about the uses of drugs in the classroom. A set of scientific and other "authoritative" references can appear to validate Mr. Arnold's criticisms until one looks more closely at them and how they are used.

The critique emphasizes the real threat that drugs will be misused to assist learning and memory. We can agree, but the report does not address

itself to the use of drugs to cure learning problems. Its subject is the place and proper use of drugs for hyperactivity and its possible disastrous end results if not properly handled. A repeated theme is that drugs alone cannot be relied on.

It can be left to the report itself to answer other issues raised by Arnold. In fact, his critique illustrates well the report's closing warning that the public cannot be protected against half-truths and sensationalism without authentic knowledge.

Arnold Arnold is a highly respected and usually authoritative spokesman about the problems of parents and children. His motives in this critique are impeccable. His interest in assuring that the needs of children are being met, especially disadvantaged and hurt children, shines through his flawed objections to this report. Let us save our harpoons for the real enemy!

The last few years have seen a deluge of reporting about the rapidly expanding incidence of drug misuse and abuse in our society. Evidence of its epidemic levels is becoming so prevalent that even those with but a casual or passing interest in the phenomenon are willing to cite drug abuse as one of our major problems. The majority of our population, seldom so articulate, are voicing their concerns for the development of programs to reduce this major threat to the physical and mental well-being of our society.

Quite naturally, the involvement of school-age children in this problem has become a focal point for concern. While admittedly we are a drug-oriented society, the skyrocketing number of young people exhibiting psychological or physiological dysfunction as a result of drug involvement has created great urgency for a response. The schools, in their traditional role, have been looked to as one of the chief institutions to reverse this appalling trend. But the schools do not exist in a state of isolation from the communities they serve. Education must reflect the needs of the individual, but it must also draw from the community those resources that can accomplish the goals established for treatment, rehabilitation and prevention of drug abuse. In the same way the family must also accept its share of responsibility if we are to move toward viable solutions. If we marshal the right coordination of efforts from the school, the family and the community into a unified response, we may reasonably expect to exert a *significant impact* upon drug abuse.

The question of how we may prevent or intervene in the behavior of those experimenting with drugs of abuse—so that they abandon them in favor of healthful, productive alternatives—remains to be fully answered. An infinite number of strategies and approaches have appeared. Each comes with its own logic and rationale. What we gain from this increasing body of techniques and strategies (as they are implemented at the program level) are some very important clues to the basic elements of effective drug education. We are now beginning to identify a set of fundamental principles which, when placed upon a framework of cooperative and coordinated programs, hold high potential for ameliorating this societal issue.

Drug Abuse: A Decision

The symptoms of drug abuse are of great concern to everyone and there is no question of the need to provide programs of treatment and rehabilitation for those who reach such a state of involvement. If we are effectively to reduce the numbers reaching this level of need, however, we must focus upon the causes. Many factors are being cited: peer group pressure, curiosity, youthful rebellion, the desire to escape from reality, the allure of expanding or enhancing experiences, accidental situations, the simple pleasure which certain drugs are said to provide the individual. To be sure, these are all suffi-

cient to explain the phenomenon of drug abuse. They serve a more valuable purpose, however, if they are considered as indicators of far deeper problems within the individual that need to be explored more carefully in order to construct comprehensive preventive programs.

One central fact is clear: except for a relatively small number of individuals who become accidentally involved, every case of drug misuse or abuse is a deliberate act. A decision is made by an individual to knowingly use some substance in quantities or for purposes that are not in keeping with legitimate or legal conditions of use. Such behavior has a high-risk potential.

Not only are there dangers from a physiological point of view, but a variety of legal implications and life-style modifications threaten the well-being of the individual. The processes of decision making thus have a direct bearing upon the problem of drug abuse and must be considered as a focal point toward which preventive programs need to be directed.

The making of decisions by an individual as they concern his immediate behavior involves a complex set of variables. At the risk of oversimplifying, we would suggest several concepts particularly relevant to the problem of drug abuse. First, the individual himself will make the ultimate determination of his behavior in those situations in which he has freedom of choice. As parents, educators and community leaders, we may have deep-seated desires to direct or influence the behavioral choices being made by our youth. We use many strategies and techniques to encourage what we believe to be the "proper" or "acceptable" decisions about a wide range of personal behaviors. For the most part, this influence is well intended, and often designed to enculturate the individual so that he will be able to function in society. In the final analysis, however, there are many behaviors which will be determined by no one other than the person performing the behavior. If we accept this premise, ways must be sought to influence the individual in his selection of behaviors by providing him with greater insights into the results of his decisions.

The second major concept appropriate to our consideration of decision making is that decisions about behavior are determined on the basis of the relationship of the perceived rewards and costs. If the costs are seen by the individual as exceeding the anticipated rewards, he will likely avoid that behavior. But if the perceived rewards seem greater than the costs, he will have little regard for the risks involved. The value judgment applied to a situation by an individual as he considers the reward-cost outcome will determine the nature of the decisions about his behavior. For these reasons, the programs and approaches directed toward the primary level of prevention must consider ways in which the valuing behavior of the individual may be strengthened. We must encourage decision making that holds less risk for the physical and mental well-being of the individual. From the reported epidemic level of drug misuse and abuse we must conclude there are many young persons who are viewing the rewards offered by drugs as exceeding whatever costs they feel the drugs may hold for them.

Values and Behavior

Dr. Louis Raths, in his discussion of values in his text *Values and Teaching* (1966), proposes that for anything to be of value it must be chosen freely from several alternatives after thoughtful

consideration of the consequences of each one. The assumption is made that there will be several alternatives from which to choose, and that some consideration will be given to the consequences. These must be considered as two prime elements in the development of any system of values. It remains to clarify why certain behaviors or lifestyles appear to be more attractive to some individuals than to others.

Those working in the field of values or the behavioral sciences are generally willing to accept the notion that attitudes condition behavior. Only by working through attitudinal development and change can desirable behavior be encouraged. Dr. Harold Lasswell has designated eight categories of values, universal to mankind, which provide us with a method of access to the delicate process of attitude formation and modification. The eight categories identified by Lasswell and adapted for education by W. Ray Rucker, Clyde Arnspiger, and Arthur Brodbeck are (1) affection, (2) respect, (3) well-being, (4) enlightenment, (5) rectitude, (6) power, (7) skill and (8) wealth.

A person's feelings about himself with respect to these eight value categories will largely determine the choices he will make. When he feels significant deprivation in any one of these categories (or combinations of them), he will be more anxious to pursue some form of behavior he perceives will ameliorate this deprivation and achieve a general feeling of personal satisfaction. The rewards hold the promise of overcoming the costs—hence his increased willingness to become involved in a variety of behaviors with higher personal risk.

So it is apparent we must construct instructional programs and provide experiences that will create within the individual higher levels of self-worth, confidence, knowledge, and personal satisfaction. We must recognize that each individual develops his own system of valuing, which is affected by his perceptions of "self" relative to the value categories described above. Under these conditions, it is reasonable to expect that the valuing behavior of an individual can be influenced to place an emphasis on the more constructive alternatives available to him which are better risks than those associated with such behaviors as drug misuse and abuse.

Objectives for Prevention Programs

It is important to establish clearly performance objectives for preventive drug education programs. Confusion in this regard has often doomed well-meaning efforts to failure.

Wanting young people to understand about the danger drugs hold for them simply is not enough. Neither is it realistic to try to convince youth that they should avoid all drugs, for we do indeed live in a drug-oriented society. An acceptable and realistic output for preventive drug education programs is a reduction in the level of drug misuse and abuse by those of a well-identified target group.

This action objective is specific, measurable and states quite simply what we want to see happen. It establishes clearly the direction for developing programs that utilize a wide variety of techniques and strategies appropriate for the unique situations in which they are to be implemented. The important difference is that they can now be coordinated or articulated into a *unified effort*.

Drug Education and the Early Years

Let us summarize the concepts we have presented and suggest how they are relevant to preschool and early elementary education. We began by proposing the need to focus upon causes of drug abuse rather than symptoms as the basis for preventive programs. Recognizing drug misuse and abuse as the result of a deliberate decision in most cases, we described the decision-making process as a key entry point in determining what action might reasonably be expected to reduce this behavior. Decisions, we saw, are affected both by available information and the valuing judgments made by the individual as he perceives the rewards he stands to gain and the costs he will be likely to incur. Ultimately, this valuing behavior will depend upon the individual's feelings about himself relative to certain categories of values which, under conditions of deprivation, may encourage the selection of behaviors that are of a greater risk. Finally, we suggested a realistic and action-oriented goal to clearly identify the performance that preventive education programs are expected to produce.

The major conclusion is inescapable. Preventive drug education programs that emphasize the development of knowledge appropriate to the age levels and maturity of the child, together with approaches that strengthen his perceptions of self-worth and personal value system, must begin as early as possible. And they must precede the initial experiences of drug misuse and abuse if they are to have deepest impact upon the long-term behavior of the individual.

Information gleaned from a number of sources including student surveys, arrest records, morbidity rates, and the observations of those in the schools and community who encounter drug misuse and abuse in the daily course of their responsibilities, suggests such programs must begin as early as the third grade, or before eight years of age. Ideally we would include the home and certainly the child's first encounter with a formal education program in preschool or kindergarten classes.

It thus follows that those closely involved with the child during these early years must assume major responsibility for providing these experiences. We cannot accept the claim by some working at these levels that there is no need for preventive programs because there is no evidence of drug abuse. For this very reason we must implement effective programs in the homes, in early elementary school classrooms, and in concerned community agencies and organizations. Happily, the above-mentioned preventive principles are being realistically applied in increasing numbers of programs. As experience is gained and as the assessment of the effectiveness of these programs proceeds, hope for successfully reducing this threat to the physical and mental well-being of our youth increases. Unfortunately, societal lag has slowed down the nation's energies. But there is reason to believe that as a result of the attention now being given to drug abuse, solutions will be found that will have broader implications for mankind and his future and that will recognize the uniqueness of each individual and his value to the total society in which he lives.

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Whenever a problem affecting a large segment of society is recognized, proposed programs designed to solve it appear. The programs may be proposed by government agencies, professional organizations, commercial interests, community groups or individuals. The tendency is for everyone "to get into the act." Such widespread interest in the solution of a societal problem is healthy, and through concerted efforts of diverse groups, progress in solving it often emerges.

But a danger exists in the development of simplistic solutions for any complex problem, in the focus on symptoms rather than on causes, and in the development of a fragmented rather than a comprehensive program.

As concern about drug misuse and abuse has increased, a multitude of *programs* have been developed. These run the gamut from education, research, training, treatment and rehabilitation programs that are sponsored and often funded by governmental agencies at federal, state and local levels; to teaching guides and resource units developed by state and local education agencies and professional associations; from packets of material and teams of speakers sponsored by service clubs and private organizations, to materials such as films, records, booklets and multi-media productions produced and marketed by commercial groups.

Although the list could be expanded many times, it serves to provide examples of the many types of programs available. In this chapter programs at the national level are described in some detail, since they have implications for all areas of the country. One state program is described in detail to indicate the scope of approaches available as well as to describe the extension of federal programs through the state to the local level. A consideration of local programs, plus criteria for such programs, is also included. No attempt is made to describe the many "ready-made" programs available to school districts or community groups. Basic philosophy and specific strategies for development of comprehensive drug education programs are included on pages 38–43.

Programs At The National Level

As the scope of drug abuse in the United States was recognized, federal agencies having responsibilities in this area intensified their programs and other agencies developed programs to try to solve the problem. At first, the programs operated in isolation; however, as the complexity of the problem of drug abuse became evident, the need for coordinated effort became obvious.

In 1970 an Interagency Coordinating Committee was established to bring the agencies together to review and coordinate the various programs. In mid-1971, President Nixon, by Ex-

ecutive Order, established a Special Action Office for Drug Abuse Prevention. The Director of this office was given responsibility for overall planning and policy setting, and for establishing objectives and priorities for all federal drug abuse training, education, rehabilitation, research, prevention and treatment programs and activities, excluding law enforcement activities. Legislation has been passed by Congress. It gives the Director management authority over many of the major drug abuse programs operated by federal agencies, in addition to the aforementioned overall planning and policy role. The final form of the legislation will undoubtedly have an impact on the type and extent of drug abuse programs operated by these agencies. Thus, current programs may undergo expansion or curtailment and new activities may be established. Persons wishing to keep up-to-date on the focus of federal programs should contact the director of drug education in their state department of education.

It is the purpose of this section to describe briefly current national level drug abuse programs having particular relevance for persons working with children in the elementary grades. No attempt is made to describe all the programs sponsored or operated by federal agencies.

Drug Education

The U.S. Office of Education is sponsoring the program that directly affects more schools than any of the other federal programs. It was started in March 1970 when President Nixon announced the creation of the National Drug Education Program in the U.S. Office of Education and released approximately 4 million dollars for it. The operation of the program, which provides for grants to all states and territories, was delegated to state departments of education. Emphasis was on provision for training local teams composed of school personnel, youth and community representatives.

The Drug Abuse Education Act of 1970 (Public Law 91-527), signed into law by President Nixon in December 1970, formalized the program previously established and authorized funding, for three years, for drug education programs. The training program that started early in 1970 was continued, although at a reduced level of funding, and two new programs were initiated. One of the new thrusts provided funds for initiation or expansion of a limited number of pilot programs on college campuses; the other for a limited number of locally-initiated, pilot, comprehensive community drug education programs.

The Drug Abuse Education Act implies that the complex nature of the drug problem makes it impossible for any one group, institution or agency to deal with it adequately. The Act indicates that drug education must be directed at the community and that drug education programs, to be effective, must involve cooperation of many groups in the community, including the schools.

The thrust planned for 1972-73 by the U.S. Office of Education places additional emphasis on community education programs, but provides for the involvement of schools. Tentative plans include the establishment of several training centers, located in various areas of the country, which will offer training to community teams. Small stipends will be available to support a team during its period of training. Emphasis will be given to both school and community representation on teams. Plans for 1972-73 also provide for continuation of the programs operated by the state departments of education and for the pilot programs established in colleges and communities in 1971, as long as they continue to meet federal guidelines.

In addition to programs developed through the Drug Abuse Education Act, the U.S. Office of Education, in 1971-72, funded eleven comprehensive drug education programs submitted

by local school districts or county education agencies under provisions of the Elementary and Secondary Education Act. Involvement of the community in the program was required.

Drug Information and Materials

In 1970 a single federal resource, the National Clearinghouse for Drug Abuse Information, was created to serve as a focal point for public inquiries. Operated by the National Institute of Mental Health, the Clearinghouse serves the public through three basic services: publications distribution, computer-based information storage and retrieval, and referrals. Educational materials, selected curricula, bibliographies, film guides and catalogs are available. Single copies are provided without charge; bulk quantities are available at cost from the U.S. Government Printing Office. Data on school, community, local and state government drug abuse programs can be retrieved from a data bank on request. Inquiries of a specialized nature are referred to appropriate federal and non-federal agencies. Request for publications should be directed to *Publications*, National Clearinghouse for Drug Abuse Information, 5600 Fishers Lane, Rockville, Maryland 20852. Inquiries for program information or guidance to available material should be directed to *Information Services* at the same address. Services of the Clearinghouse provide an excellent resource for school personnel.

Late in 1971 the National Institute for Mental Health released a series of films for teacher and parent education entitled "The Social Seminar." Copies have been distributed to each state and are available for use in teacher and community education programs. Related materials such as discussion guides are also available. The Bureau of Narcotics and Dangerous Drugs, U.S. Department of Justice, in addition to its many law enforcement responsibilities, periodically develops and makes available drug education materials. Reference to these is included in listings from the National Clearinghouse.

Funding for Local Programs

The Law Enforcement Assistance Agency administers the program established by the Omnibus Crime Control and Safe Streets Act of 1968. Block grants of funds are made to states for funding programs designed to control crime. In several state preventive drug education programs have been so funded. Information on individual state programs is available from a state's department of justice and/or its attorney general's office. The National Institute for Mental Health has funded a number of local school-community drug education programs and a few have been funded by the U.S. Office of Economic Opportunity.

Coordination

The National Coordinating Council on Drug Abuse Education formed in 1968 is a private, nonprofit organization working to combat drug abuse through education. Stated purposes of the Council are: to coordinate educational and informational efforts of organizations in the area of drug abuse; to evaluate drug abuse educational programs; to give visibility to effective programs; to evaluate and develop the role of profesional and public information in drug abuse education; to stimulate regional, state and local involvement in drug abuse education by establishing interdisciplinary committees to respond to area needs; and to provide leadership in the area of drug abuse information and education. Council membership is open to any interdisciplinary regional, state, or local organization with an interest in the Council's purposes. A publication of the Council, which is entitled *Common Sense Lives Here*, is a comprehensive community guide to drug abuse action.

Programs At The State Level

An array of programs to combat drug

abuse exists in every state, thus it is impossible to give an accurate picture of all state level activities. Perhaps the only program common to all states is the Drug Education Training Program funded by the U.S. Office of Education, and even that varies in approach from state to state. As noted earlier, this program is operated through the state departments of education and emphasis is on training school-community teams. Use of the "multiplier" effect is recommended in order to reach as many individuals as possible. Federal guidelines require that there be heavy involvement of youth in planning and conducting the programs; there must also be participation of the community as well as an approach to drug education which is integrated into the educational program at all levels and in a wide variety of subjects; and finally there must be an approach which encourages people to come together to explore their attitudes towards drug use and misuse.

California Drug Education Training Program

As an example of state operation, the California State Department of Education in the 1970-71 school year established a state training team which conducted a five-day workshop for thirty-six individuals selected and organized into six regional teams. Each of these teams conducted a four- to six-day training workshop for individuals selected and organized into sub-regional teams by the State Drug Education Training staff. Through this "multiplier" effect, 171 persons were trained who, in turn, served as trainers. Federal funds allocated to the State Department of Education were used to pay travel expenses for these individuals. Thirty-three subregional teams were trained and each conducted a four-day training session to which the Department of Education invited the local school districts to send teams. At each of the levels, teams were composed of school personnel, youth and community representatives. The general goal for the program was to provide in-depth training in the various dimensions of drug education for teams of individuals who would assume leadership roles in the development, improvement and implementation of drug education programs in schools and communities in California. The philosophy expressed at the training sessions was similar to that contained in Chapter 0. During 1970-71, approximately 2,000 individuals from 500 school districts were trained by means of this program.

The 1971-72 program was built on the foundation developed the preceding year. It started by offering six general training programs, similar to those conducted in the prior year, in various areas of the state for districts that did not participate in the 1970-71 program or for districts that wished to send another team. In addition, specialized training programs are being offered for specific groups: one series for counselors, another for curriculum personnel. Training programs are also planned for school nurses, school administrators and school board members in cooperation with their respective professional organizations. Other phases of the 1971-72 California State Drug Education Training Program offer direct consultation to local districts in the planning and development of drug education programs, and the establishment and maintenance of a depository of drug information which includes instructional materials, teaching strategies, drug curricula, sample programs, inservice training systems, selected summaries of research and other relevant items. Information about these materials is disseminated to each school district through annotated reference lists.

State Interagency Councils

Councils or committees have been established in many states to coordinate (in some instances to provide direction for) the multitude of drug abuse programs being undertaken. Some

state councils are concerned only with educational efforts; others are concerned with control, treatment and rehabilitation as well.

In California, an Interagency Council on Drug Abuse was formed in late 1968 by representatives of about forty private and public organizations and agencies concerned with drug abuse. It may be unique in that it is cosponsored by the California Medical Association and the state administration and designated as one of the Governor's official advisory groups.

Six task forces comprise the working body of the Council—Education, Treatment, Research, Administration of Justice, Legislation and Government, and Youth. Each sets its own priorities and works in its own way. Three representatives from each task force meet periodically to coordinate activities and to make recommendations in the name of the Council.

The Task Force on Education has, among other activities, developed resolutions on subjects that several member organizations have used with their respective groups, namely, on Educational Policy Determination; the Primary Responsibility of Schools Relative to Drug Education; Desired Characteristics of School Personnel Involved with Drug Education Responsibilities; Guidelines for Rental, Purchase, and Use of Instructional Materials and Audiovisual Media; a Preventive Orientation to Drug Education (Alternatives). Membership on the Task Force on Education is open to any state-level group involved in drug education and to representatives from local drug education councils and committees.

Local School-Community Coordination

Drug abuse councils or committees, which have been established in many cities and counties, serve a number of purposes. For example, they provide opportunities for groups working on the problem of drug abuse to communicate with one another, to interpret the objectives and scope of their respective programs, to coordinate programs where possible, and to determine where gaps and duplications in services exist. In areas where there are few, if any, community programs, a group of persons concerned about the problem of drug abuse may, by getting together, spark the development of needed programs. Often, school personnel have taken the leadership in bringing such groups together and in pointing out the need for specific services.

In addition to voluntary efforts to coordinate programs, California has enacted legislation requiring counties to develop a coordinated county-wide drug abuse control plan. Prevention, treatment, rehabilitation and education programs are to be included in the plan.

School personnel should become familiar with the various community groups involved in drug abuse programs. In addition to official groups, such as public health and mental health departments and law enforcement agencies, these may include: parent groups, professional organizations such as medical societies, churches, service clubs, fraternal organizations, youth serving groups, newspapers, T.V. and radio stations and numerous voluntary groups. Many of the last operate drop-in centers or "hot lines," keep in close communication with youth in the community, and offer services that the school cannot provide.

Some community groups will shun the school because they consider it "Establishment" and relatively incapable of developing dynamic drug education programs that will make an impact on today's children and youth. Other groups see the school as the one social agency that has access to all young people and thus can provide opportunities for them to examine causes for the abuse of drugs and the risks involved in such abuse, as well as provide current information about drugs. Others see the school as the place to teach facts about drugs, which many

adults believe is the single necessary ingredient of a preventive drug education program. So it is important that the school define and interpret its role, including its responsibilities and limitations, and develop, in cooperation with community representatives, a plan for a comprehensive drug education program. In addition to instruction and counseling, such a program should provide for referrals from the school to available community services. Concepts basic to a comprehensive program are included in the previous chapter and a list of criteria for such programs is included at the end of this chapter.

Materials

One problem faced by the schools and other groups involved in drug education is the plethora of audiovisual and written material labeled drug education programs. As in other instructional areas the objectives for each grade level, as well as for the total program, should be determined prior to the selection of resource materials. This is important because community groups, working without the school, sometimes provide materials and speakers that are inappropriate in terms of the instructional objectives of a program. All resource materials should be evaluated carefully for accuracy as well as for their contribution to the program.

Criteria for School-based Drug Education Programs

Since drug education programs must be developed to meet local needs, to utilize local resources, and to fit into ongoing school programs, there is no one best drug education program for all situations. However, criteria for effective programs have been identified and are listed here:

Drug education programs to be most effective should:

- **Be comprehensive in scope—starting at kindergarten and extending through grade 12**
- **Be comprehensive in approach with emphasis on both cognitive and affective areas—what an individual *can* do is based on information, what an individual *will* do is based on motivation.**
- **Have clearly stated behavioral objectives—for the total program and for each grade level**
- **Focus on causes of drug misuse and abuse**

- Be based on local needs relative to the problem of drug misuse and abuse
- Provide for ongoing staff training, with involvement of students and community representatives in training sessions
- Provide a system of evaluation
- Provide for policy statements relative to instruction and counseling as well as to the handling of students suspected of possessing, using, selling drugs
- Provide for instruction throughout the school year
- Include coverage of alcohol and tobacco along with the other drugs
- Provide for effective use of materials and resource people
- Promote constructive alternatives to drug misuse and abuse
- Place an emphasis on the individual and his interpersonal relationships and activities
- Provide for counseling that is accessible to students
- Include a referral system for students in need of counseling (which is beyond the scope of the school), treatment and rehabilitation.
- Provide for parent/adult education.

Editor's Notes

1. The following comments are from a Wednesday, February 16, 1972, news release, which offers useful information to complement that found in the preceding article:

In February 1972 four major private foundations (Ford Foundation, Carnegie Corporation of New York, Commonwealth Fund, and Henry J. Kaiser Family Foundation) announced the establishment of a new national Drug Abuse Council as an independent source of information, policy evaluation, and research funding in the field of drug abuse. The Council will be funded at from $10 million to $15 million over the next five years.

Bethuel N. Webster, a prominent lawyer and former New York City Bar Association president who has been named chairman of the Council, said it would seek "to bring a calm voice into the confused national discussion on behalf of a frightened and baffled public."

Mr. Webster said the Council intends to cooperate with state and federal agencies concerned with drug abuse. It will engage in research and other direct operations only on a limited basis. The purpose is, rather, to stimulate and fund needed research and action by other institutions and persons, and to serve them as a reliable, responsive information and planning resource.

The Council will conduct analyses using its staff or outside consultants, hold small working conferences, and provide study grants or contracts aimed at increasing the quality, quantity and availability of information. Among other activities tentatively planned are:

- the annual appointment of a few resident fellows specializing in drug abuse prevention and treatment
- creation of an up-to-date information and documentation center for use by scholars, health and law enforcement officials, and others
- guidance to local communities and other groups planning their own programs dealing with drug abuse.

For additional information write: Drug Abuse Council, 1828 L St., N.W. Washington, D.C. 20036, c/o A.E. Jefferat.

2. The U.S. Office of Education recently (March 1972) announced the selection of seven regional training and support centers for drug education under the Drug Abuse Education Act of 1970 (at San Francisco Friends of Psychiatric Research and Training; Yale University School of Medicine; University of Miami, Florida; University of Chicago; University of Minnesota; Adelphi University, Long Island, New York; and Trinity University, San Antonio, Texas. An eighth center, to open later in Washington, D.C., will be part of a national training center for drug abuse education.

What follows is a brief sampling of the vast amount of literature currently available on the topic of drug abuse. As a useful supplement to this listing see *The Drug Problem and the Schools*, ERIC Abstract Series, Number Sixteen, compiled by the ERIC Clearinghouse on Educational Management, University of Oregon, Eugene, Oregon 97403, published by the American Association of School Administrators, 1201 16th Street, N.W., Washington, D. C. 20036 (single copy $2.00).

Books

Begg, I., Franz, and D.R.A. Davies. *All About Drugs*. New York: Barnes and Noble, 1971. Lists most drugs known to be in use, their origin, history, chemistry, methods of consumption, effect and potential danger. Also investigates methods of acquiring drugs legally (and in some cases illegally) and what is being done to prevent drug pushing.

Black, Perry, ed. *Drugs and the Brain: Papers on the Action, Use and Abuse of Psychotropic Agents*. Baltimore: Johns Hopkins, 1969.

Bloomquist, Edward R., M.D. *Marijuana—The Second Trip*. Beverly Hills, Calif.: Glencoe Press, 1971. In easily-understood laymen's language, the author traces the history of marijuana from culture to culture, exploring the manner in which each society has sought to meet the problem. Includes: a survey of the drug scene, with observations of types of users and the relationship of marijuana to other drugs; a study of the language of the marijuana world and research findings from medical views on the drug's effects on the mind of the drug abuser; an analysis of the varied and controversial positions taken on marijuana; and an examination of the laws restricting marijuana use, in this country and throughout the world.

Blum, Richard, and Associates. *Drugs I: Society and Drugs*. Social and Cultural Observations. *Drugs II: Students and Drugs*. College and High School Observations. San Francisco: Jossey-Bass, 1969. These two volumes contain the results of eight years' research by Blum and his associates and include historical, cross-cultural, social and psychological studies on drug use and abuse. They are based on work covering over 200 cultures and 20,000 individual interviews and questionnaires.

Byrd, Oliver E. *Medical Readings on Drug Abuse*. Reading, Mass.: Addison-Wesley Publishing, 1970. Explores effects of drugs on the individual and society by examining medical and psychiatric evidence.

Carey, James T. *The College Drug Scene*. Englewood, N.J.: Prentice-Hall, 1968. Direct examination of "grass" and its users, with an attempt at understanding the alienation of users, their goals, and the realities of life in their community.

Chein, I., et al. *The Road to H: Narcotics, Delinquency, and Social Policy*. New York: Basic Books, 1964. A team study of the personality and family patterns of young heroin users in deprived communities. Inquiries into the rationale and effectiveness of law enforcement efforts and the resources needed for rehabilitation and treatment.

Child Study Association of America. *You, Your Child and Drugs*. New York: Child Study Press, 1971. Helpful guidelines for studying today's drug problem—why youngsters misuse drugs, how parents should react to children taking drugs, and sources to turn to for help.

Cohen, Sidney. *The Drug Dilemma*. New York: McGraw-Hill, 1968. Concise description of drug abuse. Drug abuse from an historical perspection discussed. Excellent advice to parents and educators on dealing with the drug problem.

De Ropp, Robert S. *Drugs and the Mind*. New York: Grove Press, 1957. A biochemist discusses the mental effects of chemicals in and on the brain. Though obviously dated, still a useful reference.

———. *The Master Game*. New York: Dell Publishing, Delta, 1968. For people seeking non-drug alternatives. A good subtitle might be: Beyond the Drug Experience.

Ebin, David, ed. *The Drug Experience*. New York: Grove Press, 1961. First-person accounts of addicts, writers, scientists, actresses, and others regarding marijuana, opium, opiates, peyote, mushrooms, and LSD.

Fort, Joel. *The Pleasure Seekers, the Drug Crisis, Youth and Society*. New York: Bobbs-Merrill, 1969. Comprehensive and timely study of the use and abuse of the mind-altering drugs—marijuana, LSD, barbiturates, tranquilizers, amphetamines, alcohol, and others.

Geller, Allen, and Maxwell Boas. *The Drug Beat*. New York: McGraw-Hill, 1969. Survey and assessment of the effects of three major drugs—marijuana, LSD, and amphetamines—on American life.

Gorodetzky, Charles W., and Samuel T. Christian. *What You Should Know About Drugs*. New York:

Harcourt Brace Jovanovich, 1971. Designed for high school students, the book is written in understandable language for them, outlining dangers and damage of drug abuse without moralizing. Glossary and self-test for each chapter.

Greenberg, Harvey R. *What You Should Know About Drugs and Drug Abuse*. New York: Scholastic Magazine, School Book Service, 1970. Provides facts about all the drugs available today—marijuana, amphetamines, heroin, cocaine, LSD, glue, barbiturates, alcohol—in clear, straightforward language. Discusses the initial experience with drugs, drug dependence (psychological as well as physical), effects on body functions, tolerance, withdrawal, results of an overdose and methods of treatment.

Houser, Norman W., and J. B. Richmond. *Drugs—Facts on Their Use and Abuse*. New York: Lothrop, 1969. Concise, accurate information to questions young people ask about drugs. For youngsters 12 and older.

Houston, Walter Scott. *Know About Drugs*. Columbus, Ohio: American Education Publications, 1969. Illuminates problem of marijuana, LSD, alcohol, and other drugs through examination of causes and effects. For grades 7–12.

Hyde, Margaret O., ed. *Mind Drugs*. New York: McGraw-Hill, 1968. Difference between hallucinogens and other drugs, how they affect user's personality, how they harm health, why people become dependent on them, and how to "turn on" without them.

Johnson, George. *The Pill Conspiracy*. Los Angeles: Sherbourne Press, 1967. Sum and substance of pills and their effect on takers, economically as well as chemically.

Jones, K. L., L. W. Shainberg, and C. O. Byer. *Drugs and Alcohol*. New York: Harper & Row, 1969. Written in layman's language, this complete and thoroughly scientific, well-illustrated report employs a new approach based on a continuum of drug actions and effects. Describes how actions and effects overlap and how increased dosages can lead to death; discusses and illustrates the sources and actions of commonly abused drugs; considers the social, economic, and legal complications of drug abuse; contrasts accepted use of drugs and alcohol with their abuse. Bibliography of original sources; photographs, charts, and graphs.

Land, Herman W. *What You Can Do About Drugs and Your Child*. New York: Hart Publishing, 1969. Well written, informative book that gives sound information about drugs and how to prevent a child from taking them initially.

Larsen, Earnest. *Not My Kids*. Laguori, Mo. Laguorian Books, 1970. An interpretation of the drug problem among youth through frank letters to the editor. True expression of youngsters' feelings about drugs and their parents.

Lingeman, Richard R. *Drugs from A to Z: A Dictionary*. New York: McGraw-Hill, 1969. For laymen, especially those who, through occupation or association, have become concerned with drugs; very comprehensive and informative.

Louria, Donald B. *The Drug Scene*. New York: McGraw-Hill, 1968. Surveys the drug problem, including history and current medical and sociological literature, and drug use in Great Britain and Sweden. Distinctions between users and sellers and between various types of drugs are emphasized. Changes in the penal code to acknowledge these distinctions are recommended.

———. *Overcoming Drugs*. New York: McGraw-Hill, 1971. Frank and realistic discussion of what to do about drugs, with the most frequently asked drug questions answered.

Marin, Peter, and Allan Y. Cohen. *Understanding Drug Use: An Adult's Guide to Drugs and the Young*. New York: Harper & Row, 1971. Written to help parents and other concerned adults *understand* drug use and to focus on realistic approaches to dealing with it. With sensitivity and genuine feeling the authors open up new areas of discussion, revealing some of the fundamental impulses that motivate young people in contemporary America and exploring the important concerns that trouble them. Contains substantial anthology of helpful information on all of the major drugs, explaining the ways in which used and their effects; evaluates the dangers, if any, that attend their use.

May, Walter L. *The Drug Scene*. Englewood Cliffs, N.J.: Prentice-Hall, 1970. Historical background on use of drugs, today's drug scene, motivations behind drug use, what should be done about drug users.

Nowlis, Helen H. *Drugs on the College Campus*. Garden City, N.Y.: Doubleday, Anchor Books, 1969. The results of a project undertaken by the National Association of Student Personnel Administrators and the Federal Food and Drug Administration to provide up-to-date and accurate information to students, leaders, and college administrators. Covers terminology, attitudes, sociology, law, morality, and education as they effect both the user and society. Contains annotated bibliography, glossary, and Dr. Joel Fort's comprehensive chart on drugs and their effects.

President's Commission on Law Enforcement and Administration of Justice. *Task Force Report: Narcotics and Drug Abuse*. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1967. The first 20 pages of this document constitute the report and recommendations of the President's Task Force, presenting definitive material on drugs and their effects; on enforcement, crime and penalties; on treatment and civil commitment; and on medical practice and addiction. The remainder of the document consists of appendices written by experts (notable Richard H. Blum, Ph.D., Stanford University) and covering with textbook thoroughness the field of drugs and drug abuse and social, legal, and medical factors related thereto. The report is documented throughout and Dr. Blum's material is supported by extensive bibliographies.

President's Commission on Marijuana and Drug Abuse. *A Signal of Misunderstanding*. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1972. Contains controversial views of members of this Commission on how to deal with the problem of drug abuse.

Siragusa, Charles. *Trail of the Poppy*. Englewood Cliffs, N.J.: Prentice-Hall, 1966. Author tells the story of 25 years of battling the forces of crime—especially illicit drug trade.

Smith, D.E., ed. *The New Social Drug: Cultural, Medical, and Legal Perspectives on Marijuana*. Englewood Cliffs, N.J.: Prentice Hall, 1970.

Smith, Kline and French Laboratories. *Drug Abuse*. Philadelphia, Pa.: The Laboratories, 1968. Basic information on both the legal and illegal use of abusable drugs and other chemical agents.

——. *Drug Abuse: Escape to Nowhere*. Washington, D.C.: National Education Association, 1967. A valuable guide for educators. Compendium of standard material on drugs and the drug abuser. Contains an interesting historical perspective on man's use of drugs from the stone age to the present. Proposes school policies and procedures, including an educational program, for preventing and controlling drug abuse among students; stresses the desirability of cooperation among school, parents, physicians, and police in behalf of student welfare. Contains helpful appendix material, including a reference chart on drugs commonly abused.

Stearn, Jess. *The Seekers*. New York: Doubleday, 1969. In this survey of the use of marijuana, LSD, amphetamines, and narcotics in the U.S., the author records the thoughts and aspirations of youthful pot smokers, LSD users, and heroin addicts. The relationship between marijuana and the stronger drugs is discussed.

Taylor, Norman. *Narcotics, Nature's Dangerous Gifts*. New York: Dell Publishing, 1970. Historical perspective on the plants that provide man with his "flight from reality." Author, a noted botanist, traces the social use of these drugs, from discovery to recent times, in anecdotal fashion. Interesting background information, though out of date in dealing with the current drug scene in America.

Wrenn, C. Gilbert, and Shirley Schwarzrock. *Facts and Fancies About Drugs*. Circle Pines, Minn.: American Guidance Service, 1970. Basic report on the drug scene for upper elementary and junior high school. Presents information about the many substances with which some young people experiment.

——. *The Mind Benders*. Circle Pines, Minn.: American Guidance Service. As people eat to satisfy their emotions and smoke to feel at ease, so they use alcohol to relax and forget and use other drugs for similar reasons. The conflict between drug users and society, the motivation for drug use, the drug scene as experienced by an addict, and the laws about drugs are examined.

Films

Answer Is Understanding, The. 1971. 30 min., sound, color. Producer: National Institute of Mental Health. Distributor: National Audiovisual Center (GSA), Distribution Branch, Washington, D.C. 20409. Sale: $119.50. Rental: $12.50. Audience: general. Synopsis: In this combined, shortened version of the three films in "The Distant Drummer" series, a survey is made of the phenomenon of drug abuse. The story shows some of the origins and history of addictive drugs; ways in which many kinds of drugs are now being abused; the penalties; public attitudes toward drug use; recent research; and modes of treatment and rehabilitation.

Anything for Kicks. 1971. 9 min., sound, color. Producer: National Institute of Mental Health. Distributor: National Audiovisual Center (GSA), Distribution Branch, Washington, D.C. 20409. Sale: $44.75. Rental: $7.50. Audience: adult. Synopsis: Portrays in filmograph technique the plight and eventual fate of a teenage couple who become addicted to heroin. Based on the actual words and experiences of the couple, this film dramatically provides insight into the life style of the youthful, middle income, suburban addict. It sets the stage for youth and adults to discuss the problem.

Are Drugs the Answer? 1970. 26 min., sound, color. Producer: National Institute of Mental Health. Distributor: National Audiovisual Center (GSA), Distribution Branch, Washington, D.C. 20409. Sale: $96.25. Rental: $10. Audience: junior, senior high school. Synopsis: Depicts a low-keyed classroom discussion by psychologist Allan Cohen. Dr. Cohen, a former disciple of Timothy Leary, conducts informal discussions with junior and senior high school students all around the country. In this session Cohen discusses the nature and harmful effects of various kinds of drugs, such as the psychedelics, speed, and marijuana. He also tells why he has turned away from the drug scene. A question and answer session follows the talk. Cohen does not sermonize, and his manner is light and relaxed.

Beyond LSD. 1968. 25 min., sound, color. Producer and distributor: Bailey Film Associates of California, 11559 Santa Monica Blvd., Los Angeles, Calif. 90025. Sale: $300. Audience: adult. Synopsis: This film covers the communication gap between two generations, teenagers and young adults on the one hand and those over thirty—"the Establishment"—on the other. A group of parents seeks help in order to understand why alienation between parents and children may lead to drug use.

Community as the Doctor, The. 29½ min., sound, color. Producer and distributor: Dick Hain Productions, 459 Hamilton Ave., Palo Alto, Calif. 94301. Sale: Apply to producer. Audience: general. Synopsis: A series of interviews and vignettes show what one town of 22,000 people—Pittsburg, California—did about the drug abuse problem. The people who organized the project tell of their determination as well as their problems in unifying the town behind an effort to set up a drug abuse center. They describe the success of the effort and lay down a series of guidelines for other communities to follow in making a similar effort.

Crisis House. 1970. 22 min., sound, color. Producer and distributor: Churchill Films, 662 N. Robertson Blvd., Los Angeles, Calif. 90069. Sale: $240. Audience: senior high, parents. Synopsis: The young people living at Crisis House have been drug users; they are attempting to reshape their lives without drugs. In rap sessions they try to face their feelings toward themselves and their environment.

Day in the Death of Donny B., A. 1970. 15 min., sound, b&w. Producer: National Institute of Mental Health. Distributor: National Audiovisual Center (GSA), Distribution Branch, Washington, D.C. 20409. Sale: $32.50. Rental: $7.50. Audience: junior, senior high school, professional, adult. Synopsis: Describes the day of a heroin

addict in the inner city. The setting is in the streets and alleys of a neighborhood which could be Harlem, Hough, or Watts. The addict is Donny B., who is young, black, and isolated from the rest of his world—its pride and achievements. There is no narration in this film except for the voices of mothers, ex-addicts, policemen, clergy, storekeepers, and doctors who themselves live amidst the junkie scene. They talk about the need for help and understanding of the problems of addiction. The speakers express the opinion that drug addiction is part of an array of problems which reach throughout our entire society and can no longer be ignored.

Darkness, Darkness. 27 min., sound, color. Distributor: Bureau of Narcotics and Dangerous Drugs, 1405 I St., N.W., Washington, D.C. 20005. Audience: junior, senior high school, professional, adult. Synopsis: A study of the heroin addict—young, white, and middle class. It enables the "junkies" themselves to tell and show what heroin addiction means. The film encapulates the heroin experience: the cause of heroin experimentation, the professes of addiction, and the actual states of addiction.

Distant Drummer, The. 1969. A series, 22 min. each film, sound, color. Producer: National Institute of Mental Health. Distributor: National Audiovisual Center (GSA), Distribution Branch, Washington, D.C. 20409. Sale: $74.75 each; $153 for the series. Rental: $10 each, $15 for the series. Audience: adult. Synopsis: Part I, *Flowers of Darkness*, provides historical survey of the drug abuse problem. Part II, *A Moveable Scene*, visits the drug scene among youth in San Francisco, New Orleans, and London. Part III, *Bridge from No Place*, describes the process by which ex-addicts may rejoin society through treatment and rehabilitation. Narrations are by Robert Mitchum, Paul Newman, and Rod Steiger. Describes attitudes of the public toward drug addiction and presents the point of view of the users themselves. Inner city residents, students, parents, researchers, and law enforcement officials are heard. The films span the entirety of the drug abuse problem and seek to define the broader social issues involved.

Drug Abuse: A Call to Action. 27 min., sound, color. Producer: John G. Fuller, Portside Productions. Distributor: Association Instructional Materials of Association Films, Inc., 600 Madison Ave., New York, N.Y. 10022. Sale: $300. Rental: $20 per day, $40 per week. Audience: junior high school and above. Synopsis: Strikes directly at the community problem in combatting drug abuse. In real situations filmed on location in Greenwich, Connecticut, it suggests what can be done through coordinated voluntary action from the point of view of parents, teachers, children, doctors, police departments and other organizations when a well-shaped plan is instituted.

Drug Abuse: Everybody's Hang up. 1970. 14 min., sound, color. Producer: Smith, Kline and French Laboratories. Distributor: National Education Association, 1201 16th St., N.W., Washington, D.C. 20036. Sale: $90. Preview charge for three days: $5. Audience: school and college teachers, administrators, community groups and parents. Synopsis: A documentary-type look at the drug abuse scene, this film attempts to heighten awareness of, and concern with, the problem. The film does not attempt to provide answers to this difficult problem but, rather, offers suggestions that may help parents keep their children off the chemical road to nowhere.

Drugs and the Nervous System. 1967. 18 min., sound, color. Producer and Distributor: Churchill Films, Inc., 662 N. Robertson Blvd., Los Angeles, Calif. 90069. Sale: $180. Rental: write for price. Audience: junior, senior high school, college. Synopsis: Animation is combined with photographic vignettes to illustrate effects of various classes of drugs on the human body and mind. The nature of drugs and their effect on the nervous system are introduced through a discussion of the use of aspirin as a pain reliever. Film then discusses use of amphetamines, barbiturates, narcotics, marijuana, LSD, and volatile substances such as glue. Therapeutic uses of drugs, effects sought by abusers, and the results of abuse are explained. It also examines the possible reasons for the use of drugs by pre-teen or early teenagers and touches upon the harmful effects of LSD and the moral and legal issues surrounding the use of marijuana.

Drugs Are Like That. 1969. 17 min., sound, color. Distributor: Junior League of Miami, Inc., 700 Biltmore Way, Miami, Fla. 33434. Sale: $140. Audience: early elementary. Synopsis: Psychologically aimed at preventing the kindergarten and early elementary-age child from experimenting with drugs. The film, with discussion guide included, does not moralize or employ scare tactics.

Eleven Fifty-Nine: Last Minute to Choose. 1971. 28 min., sound, color. Producer: Bretano Foundation. Distributor: Holt, Rinehart, and Winston, Inc., 383 Madison Ave., New York, N.Y. 10017. Sale: $375. Audience: senior high through adult. Synopsis: Heavy users of various drugs, including heroin, stimulants, and depressants, discuss their lives and their reasons for using various drugs. A young woman tearfully describes her "wasted" state to a counsellor. Interspersed are scenes showing emergency room procedures for overdose victims in a San Francisco hospital.

Escape from Addiction. 27 min., sound, color. Producer: American Association Against Addiction. Distributor: Richard S. Milbauer Productions, 21 W. 46th St., New York, N.Y. 10036. Sale: $225. Audience: General. Synopsis: An authority on addiction, R. Gordon Bell, M.D., gives a straight-forward lecture on drugs. He first discusses the chemical nature of various drugs producing dependence, and then explores the nature of dependence on alcohol and ways of recovery from this dependence.

Everybody's Going Where I've Been. 14 min., color, sound. Producer and distributor: Billy Budd Films, 235 E. 57th St., New York, N.Y. 10022. Sale: $175. Audience: general. Synopsis: A folksinger, Juniper, describes his concern for others as a result of friends' involvement with drugs. As he sings his song, the narrative is acted out by a young man and woman. The story serves as a strong stimulus for discussion.

For Adults Only. 28 min., sound, color. Producer and distributor: Professional Arts, Inc., P.O. Box 8484, Universal City, Calif. 91608. Sale:

$300. Rental: $30. Audience: adult. Synopsis: A film director, a group of actors, and technical consultant Allan Y. Cohen offer strategies, techniques, and ideas for adults in responding to young people's experiences and comments on drugs. The actors play the roles of a father, mother, 17-year old daughter, and high school teacher who demonstrate both unproductive and productive ways in which younger and older people can communicate about drug use. Various approaches, such as honest and unemotional discussion between parent and youngster, or teacher and class, and the importance of factual drug knowledge, are demonstrated, as well as the need for exploration of meaningful alternatives to drug use.

Grooving. 1970. 31 min., sound, color. Producer and distributor: Benchmark Films, Inc., 145 Scarborough Rd., Briarcliff Manor, N.Y. 10510. Sale: $390. Rental: $40. Audience: junior, senior high school. Synopsis: No actors, no script, no adults. A group of 14 to 18-year-olds—drug users, non-users, and ex-users—confront each other for several days, probing one another's motivations and the social acceptability of users as well as non-users who seemingly "groove on reality."

Hide and Seek. 1966. 14 min., sound, color. Distributor: Center for Mass Communication of Columbia University Press, 440 W. 110th St., New York, N.Y. 10025. Sale: $168. Rental: $16.80 per day. Audience: junior, senior high school. Synopsis: A boy's personal story of his life as an addict. Starting with his initiation to drugs, the film follows his steady mental and physical deterioration. What clearly emerges is the boy's remorse, his insurmountable loneliness and extreme anguish. Good technical accuracy, strongly effective in reaching the desired audience and good dramatic effect.

Holy Smoke. 1970. 8 min., sound, color. Producer and distributor: Billy Budd Films, Inc., 235 E. 57th St., New York, N.Y. 10022. Sale: $95. Rental: $15. Audience: junior, senior high school. Synopsis: This animated film, with music and a lighthearted style suggestive of an old-time movie, attempts to express how young people themselves feel about drug information, and how the more insightful of them would go about dealing with the problem. In three acts, it expresses a student view of drug information, showing how it can be depressing and counterproductive, depicts the angry reaction engendered by exaggerated scare tactics; and offers positive answers aimed at discussion. Accompanied by teacher's guide, which is essential in helping the teacher present the film with understanding and in stimulating useful discussion.

Hooked. 1966. 20 min., sound, b&w. Producer and distributor: Churchill Films, Inc., 662 N. Robertson Blvd., Los Angeles, Calif. 90069. Sale: $125. Rental: write for price. Audience: junior high school through college. Synopsis: Film consists of statements by young (ages 18-25) former heroin addicts concerning their past experiences with drugs. They are filmed in various institutional settings, including jails and halfway houses. All had been off drugs for periods ranging from 3 months to 2 years and considered addiction a thing of the past. Their reminiscences cover all aspects of being "hooked"; how they got started, how it feels to get arrested, to kick the habit, and what their families experienced along with them. In retrospect, they see no glamour in the stealing, prostitution, forgery, and breakdown of personal relationships that accompanied their use of drugs. They speak with regret and disgust. Words, facial expressions and voice tones come across powerfully. Good photography and editing. Discussion guide available.

It Takes a Lot of Help. 27 min., sound, color. Producer: Kemper Insurance Group and National Coordinating Council on Drug Abuse Education. Distributor: Modern Talking Picture Service, Inc., local offices. Sale: $65. Free loan. Audience: general. Synopsis: The film, narrated by movie and television personality Lorne Greene, involves the viewer in an in-depth analysis of citizen-initiated drug prevention programs in Cedar Rapids, Iowa, group therapy sessions in Chicago, a dramatic conversation on Boston's narcotics "hot line," and actual drug free sensitivity trip in the forests near Tucson, and much more.

The Losers. 1965. 31 min., sound, b&w. Distributor: Carousel Films, Inc., c/o Associations Films, 600 Grand Ave., Ridgefield, N.J. 07657. Sale: $145; Rental: $16. Audience: junior, senior high school. Synopsis: This excellent exposition of the narcotic's problem in relation to teenagers will serve to sharpen the awareness of young people to the damage caused by drug addiction and should be seen by all adolescents and adults. Clearly shows harmful effects of such practices as glue sniffing, use of pep pills, goof balls, heroin and marijuana. Cuts across social and economic lines. Actual experiences from "high hazard" slums and "nice" neighborhoods.

LSD-25. 1967. 27 min., sound, color. Producer and distributor: Professional Arts, Inc., P.O. Box 8484, Universal City, Calif. 91608. Sale: $275. Rental: $27.50. Audience: senior high school. Synopsis: The chemical compound LSD-25 is given a voice and speaks to viewers of its properties and effects, with emphasis on facts about the drug. Scenes illustrating the narrative accompany the voice. Discussed are potency, uncertain dosages produced by backstreet chemists, alterations in brainwave tracings following use, possible cell changes, and chromosomal damage. The voice of LSD tells of bad trips, self-injury, suicide, and recurrent echoes of the experience which it can produce and of variation in reactions, which depend not only on the drug but also on the chemistry of the user. A balanced and factual presentation of LSD.

Nice Kid Like You, A. 1969. 39 min., sound, b&w. Produced by Eugene Lichtenstein for The Group for the Advancement of Psychiatry. Distributor: Extension Media Center, University of California, Berkeley, Calif. 94720. Sale: $250. Rental: $15. Audience: adult. Synopsis: A group of college students, some of whom have used drugs, talk about their life experiences. They are interviewed on their campuses and explore the subjects of drugs, sex, social problems, politics, and the current position of youth in this country. Drug use and involvement with the law as a result of selling marijuana are only a part of the contemporary scene depicted by the students. The whole question of changing values from the past generation to the present one is also explored. Relationships and communication with parents are discussed critically. The film voices

the widespread feeling of young people that established authority no longer has any meaning for them.

Not Me. 1970. 30 min., sound, b&w. Distributor: New Jersey Community Action Training Institute, 2465 S. Broad St., Trenton, N.J. 08610. Sale: $175. Rental: $15. Audience: junior, senior high school, college, adult. Synopsis: Story of heroin use in the black ghetto. The film deals, in drama form, with a young Puerto Rican boy who succumbs to peer group pressure until he becomes a drug dependent. It follows his struggle with heroin addiction to the end, which, in his case, is an accidental overdose.

Riddle, The. 1966. 20 min., sound, b&w. Distributor: Public Affairs, Office of Economic Opportunity, 1200 19th St., N.W., Washington, D.C. 20506. Sale and rental information upon request. Audience: junior, senior high school. Synopsis: Stripping drug abuse of any vestiges of glamour, the camera follows actual glue sniffers, cough medicine drinkers, and heroin addicts into alleys, tenements and physicians' offices where their candid comments and bewildered responses clearly illustrate the hopelessness of their lives. By contrast, an account of a youth who resists the drug abuse crowd to land a job strikes a hopeful note.

Scag. 1970. 21 min., sound, color. Producer and distributor: Encyclopedia Britannica Educational Corp., 425 N. Michigan Ave., Chicago, Ill. 60611. Sale: $265. Rental: $10 for 1 to 3 days, $2 per additional day. Audience: high school through adult. Synopsis: Relates in their own words the experiences of two heroin addicts—a middle class white male and an inner-city black girl. The narration illustrates how a $40 poppy crop from Turkey becomes a supply of heroin—scag—with an estimated value of $280,000 on New York City streets. Finally, the narration focuses on several rehabilitation facilities, including Goudengia House in Philadelphia, and the use of methadone in rehabilitation.

The Seekers. 1968. 31 min., sound, color. Producer: New York State Council on Drug Addiction. Distributor: Benchmark Films, Inc., 145 Scarborough Rd., Briarcliff Manor, N.Y. 10510. Sale: $390. Rental: $40. Audience: junior, senior high school. Synopsis: An unscripted film documented as it happened. Young ex drug abusers tell about the physical and psychological damage they suffered from using drugs and how they learned to face reality instead of escaping from it through drugs.

Single Concept Drug Films. 1971. Nine films, each 5 min., sound, color. Producer: National Institute of Mental Health. Distributor: National Audiovisual Center (GSA), Distribution Branch, Washington, D.C. 20409. Sale: all on one reel, $153; nine separate reels, $181.25 Rental: $17.50. Audience: general. Synopsis: The nine topics covered are: general drug abuse, alcohol, hallucinogens, stimulants, and cigarette smoking. The history, use, effects, and risks of all the drugs are discussed.

Social Seminar, The. 1971. Series of 15 films, 30 min. each, sound, color. Producer: National Institute of Mental Health. Distributor: National Audiovisual Center (GSA), Distribution Branch, Washington, D.C. 20409. Sale: (entire series) $857.25. Rental: (entire series) $197.50. Audience: Restricted to educators, for teacher training.

Speedscene: The Problem of Amphetamine Abuse. 1969. 17 min., sound, color. Producer: Medi-Cine Films. Distributor: Bailey Film Associates, 11559 Santa Monica Blvd., Los Angeles, Calif. 90025. Sale: $210. Rental: $15. Audience: junior, senior high school, college, adult. Synopsis: The nature, effects, and conditions surrounding abuse of amphetamines are explored in detail. Several physicians and researchers describe typical reaction patterns to the drug—the immediate high, poor impulse control, possibility of violence-prone behavior, disinterest in sleep and food, the crash and profound depression following the high, and finally the beginning of a new cycle. Some of the people who run the risk of becoming involved with amphetamines are described as housewives on diet pills, those engaged in monotonous work, and students taking exams. The subculture and life style of those on speed are discussed. The more serious effects on the body from injection of methamphetamine are reported—hepatitis, abscesses, bad gums, skin problems, malnutrition, and anxiety states resulting in paranoia. Some of the therapeutic uses of this class of drugs are also noted along with the descriptions of its abuse.

Us. 28 min., sound, color. Producer: Robert Appelbe. Distributor: Churchill Films, 662 N. Robertson Blvd., Los Angeles, Calif. 90069. Sale: $295. Audience: senior high, adult. Synopsis: A series of ironic, unstaged vignettes showing people of all kinds using alcohol, tobacco, and other drugs while deploring the inhumane world about them.

Magazines

Blavat, Herbert, and William Flocco. "A Survey of a Workable Drug Abuse Program." *Phi Delta Kappan*, May 1971. Relates how a Los Angeles high school assumed responsibility for educating its students about drugs.

California State Department of Public Health. "Drug Abuse." Reprints from *California Health*, monthly publication of the Department, Berkeley, Calif.

Cohen, A. Y. "Inside What's Happening: Sociological, Psychological, and Spiritual Perspectives on the Contemporary Drug Scene." American Journal of Public Health 59, 11 (1969): 2092-2095.

———. "Psychedelic Drugs and the Student: Educational Strategies." *Journal of College Student Personnel*, March 1969. (Available from the Committee for Psychedelic Drug Information, San Francisco, Calif.)

Dahlberg, Charles C. "Let's Stop Lying About Drugs." *Medical Economics*, April 20, 1970: 112-118. A psychiatrist dissects the "half-truths, myths, and plain lies" told by apologists for drug users and even those favored by medical doctors.

Dupont, Robert L., and Richard N. Katon. "Development of a Heroin-Addiction Program—Effect on Urban Crime." *Journal of American Medical Association*, May 24, 1971. Report on

how educators learn to understand and help students with drug problems. Reference to drugs and "hippie" culture.

Halleck, Seymour. "The Great Education Hoax." *The Progressive*, July 1970. Contends drug abuse is a symptom of human despair which pervades society, and drug education a strategy designed to treat symptoms rather than causes of illness.

Herzog, Elizabeth, et al. "Drug Use Among the Young: As Teen Agers See It." *Children*, November-December 1970. Outline of general patterns of response of teen-age school children to questions asked by young reporters from the U.S. Children's Bureau. The young people's reports show some points of strong consensus, some points on which opinions divide rather evenly, and some on which a dissenting minority is substantial.

Hollister, William G. "Signs of Drug Abuse." *National PTA Bulletin*, January 1970: 6. Outlines signs of drug abuse of glue, marijuana, stimulants, barbiturates, narcotics, and LSD.

Kinne, Louise. "State Drug Abuse Fight Under Way." *Social Services in Wisconsin*, April-June 1970. How one state is fighting the battle against drug abuse through government and citizen cooperation.

Linkletter, Art. "We Must Fight the Epidemic of Drug Abuse." *Reader's Digest*, February 1970. A famous father speaks from tragic personal experience about a problem that threatens every family.

May, Edgar. "Drugs Without Crime." *Harper's*, July 1971: 61-65. A report on British "success" with heroin addiction problem.

Scholastic. "Some Straight Talk About Drugs." *Senior Scholastic*, March 1970: 4-10. Offers explanation for increase in drug use not only in the ghetto, but also among the middle class and the affluent.

Shachter, Burt. "Psychedelic Drug Use by Adolescents." *Social Work* 13, 3 (July 1968): 33-39. A background presentation about the growth of the psychedelic drug culture among adolescents, concentrating on the implications of the patterns of a major psychedelic drug, LSD, for future human development.

Winick, Charles. "Drug Addicts Getting Younger." *PTA Magazine*, September 1970. Close look at drug abuse by children 8-12 years of age.

World Health Organization. "Drugs." *World Health Magazine*, April 1971. Describes current drug scene, facts about drugs, a guide to various drugs, portrait of an ex-drug addict who didn't make it, drug abuse in New York City, drugs in Hong Kong, international approach to drug addiction treatment programs.

Pamphlets

American Association for Health, Physical Education and Recreation. *Drug Abuse: A Primer for Parents*. Washington, D.C.: The Association, 1967. Describes drug abuse, its effects, and possible roles for the parent.

Blaine, Graham B., Jr. *Why Intelligent Young People Take Drugs*. Albany, N.Y.: New York State Narcotic Addiction Control Commission. Reviews rise in the taking of drugs and the physiological and psychological effects that make drugs attractive.

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California Youth Authority Board. *Drug Abuse*. Sacramento, Calif.: California Office of State Printers, 1970. Represents an effort by government agency, PTA, and medical association to answer questions most frequently asked about drug abuse. Non-technical.

Connecticut Department of Mental Health. *Free Standing—Drug Education Program for Parents*. Hartford, Conn.: Connecticut Alcohol and Drug Dependence Division, June 1970. Program designed for parents with information about drugs and the interrelationship between their children and drugs.

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Food and Drug Administration. *The Use and Misuse of Drugs*. Washington, D.C.: U.S. Government Printing Office. Resource curriculum guide and safe use of drug products.

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Kiwanis International. *Deciding About Drugs*. Chicago, Ill.: Kiwanis International, 1969. Both "sides" of drug use, asking youth to make the decision when confronted with the drug question.

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McBride, Joyce. *Drugs*. Sacramento, Calif.: California Delinquency Prevention Commission. Brief study of the drug abuse problem among youth with guidelines for possible solutions.

Manitoba Department of Health and Social Development. *Drugs*. Manitoba, Can: Educational Services, the Department, 1970. Directed not only to young people who abuse drugs, but to anyone who uses potent drugs for other than necessary medicinal purposes.

Michigan Governor's Office of Drug Abuse. *The Next Step—Informing Yourself on What It's All About*. Lansing: The Governor's Office, 1970. Basic drug information booklet with material on marijuana, hallucinogens, narcotics, amphetamines, barbiturates, solvents, and alcohol. Includes glossary, summary chart, and answers to often-asked questions.

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National School Public Relations Association. *Drug Crisis: Schools Fight Back with Innovative Programs*. Washington, D. C.: The Association, 1971. An *Education U.S.A.* Special, written by J. William Jones with the help of the staff of *Education U.S.A.* Discusses in detail drug abuse education across the country, reporting on programs that work and those that do not.

New Hampshire Program on Alcohol and Drug Abuse, Division of Public Health. *Drug Dependency* ("Quo vadis"). Concord, N.H.: The Division, February 1971. Brief appraisal of the drug scene with definitions, effects, and route to drug use and abuse.

New York State Narcotic Addiction Control Commission. *Questions and Answers* (on commonly abused drugs). Separate pamphlets: *Heroin—the Crutch, Delirients, Barbiturates, Cocaine, Amphetamines* and *Marijuana*. Albany, N.Y.: The Commission. Brief resume of the drugs and their use and abuse; interestingly written.

Oklahoma State Department of Health, Office of Public Information. *Drug Abuse. A Capsule Report*. Oklahoma City, Okla.: The Department. Concise informative description of drug use. Written in easily-understood language. Two persons who have spent a major portion of their lives working with drug addicts describe the addict's message and their approaches to him.

Pennsylvania Department of Health, Division of Drug Control. *Dangers of Drug Abuse*. Harrisburg, Pa.: The Department. Outlines answers to questions about drug abuse.

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———. *Narcotics*. Harrisburg, Pa.: The Department. Short survey of the history of commonly abused narcotics.

Read, Donald A. *Drugs and People*. Boston: Allyn and Bacon, 1969. Presents a total view of drugs, including physical, social, medical, psychological, legal, and ethical implications of use and abuse.

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Saltman, Jules. *What About Marijuana?* New York: Public Affairs, 1970. Historical background on the use of marijuana in the civilized world, its acceptance in today's subculture.

———. *What We Can Do About Drug Abuse*. New York: Public Affairs, 1966. Analysis of today's drug problem with suggestions involving private and governmental assistance in possible solutions.

Shiller, Alice. *Drug Abuse and Your Child*. New York: Public Affairs, 1970. Suggestions for parents on handling drug abuse problems among children.

Smith, Kline and French Laboratories. Drug Abuse: *The Empty Life*. Philadelphia, Pa.: The Laboratories, 1967. Resume of facts and fallacies of drug use, the human cost of drug abuse, and comments on the use and abuse of amphetamines, barbiturates and narcotics.

Social and Rehabilitation Service. *Youthful Drug Use*. Washington, D.C.: U.S. Government Printing Office, 1970. Series of surveys of drug use in nine college and community areas; useful in understanding drug problems among youth.

Tennessee, University of, Student Pharmaceutical Association. *Drugs, the Dangerous Darlings*. Memphis, Tenn.: Holiday Press. Collection about mind- and body-altering drugs, chemical and plant substances. Designed to illustrate the dangers and also medical applications under controlled conditions.

Vogel, Victor H. and Virginia E. *Facts About Narcotics and Other Dangerous Drugs*. Chicago, Ill.: Science Research Associates, Inc. 1967. Designed to help young people better understand and solve personal problems related to drugs.

Wilkerson, David. *What Every Teenager Should Know About Drugs*. Minneapolis, Minn.: Bethany Fellowship, Inc., 1968. A minister's personal account of his counseling experiences with young addicts.

Winick, Charles, and Jacob Goldstein. *The Glue Sniffing Problem*. Greenwich, Conn.: Greenwich Health Association. Facts and theories on the extent of glue sniffing among the young.

Wisconsin Department of Health and Social Services. *Drug Dependency*. Madison, Wis.: The Department. Outlines different types of drug dependency as classified by the World Health Organization.

———. *Decisions . . . Decisions About Drugs*. Madison, Wis.: The Department. Brief Summary of drug abuse, how drugs are taken, why people abuse, and possible dangers.

Wolk, Donald J. *Drugs and You*. Washington, D.C.: National Council for the Social Studies, 1971. Probes the various components of the drug scene. Topics range from student attitudes rerarding drugs to the psychological and sociological reasons for drug use.

Yardley, Quintin. *Another Book on Drugs*. St. Catherine, Ontario, Can.: BrockUniversity Students' Union, Inc., 1970. Balanced, humane examination of drug use that offers both a factual and a sociological perspective. Discusses various factors that determine the drug experience, as well as the drugs themselves (alcohol, amphetamines, cannabis, LSD).

Yolles, Stanley. *An Expert Answers Teenagers' Questions About Drugs*. Albany, N.Y.: New York State Narcotic Addiction Control Commission. Answers questions about drugs posed by young people: Can I become addicted to "pot"? Will using "pot" lead to other drugs? What can happen during a "bad trip" on LSD? Gives steps parents can take in dealing with the drug abuse problem.

Selected ACEI Publications

Aides to Teachers and Children Practical and informative discussions on selection and training of aides. Bibliography. 1968. 64 pp. $1.50.

Children and Today's World Articles on values by authorities in seven disciplines. 1967. 68 pp. $1.25.

Children of Resurrection City Hope for poverty's children as seen by a child psychiatrist and a Head Start teacher. 1970. 48 pp. $1.50.

Children's Views of Themselves In 9th printing. Self-estimates in behavior; self concepts; how adults can estimate. 1959. 36 pp. 75¢.

Child's Right to the Expressive Arts ACEI position paper by Arne J. Nixon. 1969. 12 pp. 15¢ ea.; 25 copies $3.

Child's Right to Quality Day Care ACEI position paper by Annie L. Butler. Outlines standards for day care planners to consider—environment, educational program, staff selection, parent involvement. 1970. 8 pp. 20¢ ea.; 25 copies $4.

Creating with Materials for Work and Play Portfolio of 12 leaflets on selecting and using drawing and painting materials; 3-D and natural materials; tools and props for play, science; formulas for making. 1969 rev. $1.25.

Don't Push Me In 9th printing. Pressures that motivate; those that harm children; formal instruction too early. 1960. 40 pp. 75¢.

Feelings and Learning Five educators discuss how feelings are interwoven into many areas of children's development: social, intellectual and physical. 1965. 118 photos. Hardcover book, 96 pp. $5.95.

Learning Centers: Children on Their Own Techniques of individualized teaching and learning. 1970. 84 pp. $2.

Let's Create a Form San Diego County art guide on 3-D materials; developmental levels. Full-color illustrations. 1969. 54 pp. $2.50.

Migrant Children: Their Education Teaching children of migrants; inservice training programs; bridging language gaps; the community; projects; references. 1971. 64 pp. $2.

Nutrition and Intellectual Growth in Children Nine articles attesting to timely evidence of grave interrelationship between malnutrition and intellectual growth in children. Illus. 1969. 64 pp. $1.25.

Parents-Children-Teachers: Communication Discusses 3-way relationship of communication as key to building understanding, trust and mutual helpfulness. 1969. 75 pp. $1.75.

Physical Education for Children's Healthful Living New concepts of physical education. Basic movements, sequential skills. 1968. 80 pp. $1.50.

Play Is Valid ACEI position paper by Lawrence Frank that supports play as genuinely productive and necessary for children. 1968. 8 pp. 20¢ ea.; 25 copies $4.

Playgrounds for City Children Transformation of playgrounds into environments for living and learning; photographic essays. 1969. 56 pp. $1.50.

Young Deprived Children and Their Educational Needs Discusses environmental factors shaping children's lives; experiences. 1967. 16 pp. 25¢ ea.; 10 copies $2.

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